Evaluation of the Process and Impact of State Outreach and Enrollment Programs for Dual Eligibles

Final Report

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EXECUTIVE SUMMARY

RTI International[1] was awarded a contract from the Centers for Medicare & Medicaid Services (CMS) to conduct an evaluation of programs in States that received grant funding to promote outreach and enrollment in the Medicare Savings Programs (MSP). This report provides an evaluation of programs in the six States that received grants to perform outreach for the MSP and analyzes the relationship between these outreach activities and enrollment.

Background of the Grant Program

Under the Government Performance and Results Act (GPRA), one of CMS' initiatives is to identify and enroll more dual eligibles into the MSP. The MSP consist of five programs:

- Qualified Medicare Beneficiaries (QMB);
- Specified Low-Income Medicare Beneficiaries (SLMB);
- Qualified Individuals I (QI-1);
- Qualified Individuals II (QI-2); and
- Qualified Disabled Working Individuals (QDWI).

Medicaid assists enrollees in these five programs in paying for their Medicare premiums and, in some cases, their deductibles and coinsurance. Enrollees in the QMB programs have their Medicare Part B premiums paid, as well as their deductibles and coinsurance.[2] Medicaid only pays the Part B premiums for SLMBs and QI-1s, while QI-2s are reimbursed a small amount to make up for annual Part B premium increases ($3.91 per month in 2002). Medicaid covers the Part A premiums for QDWIs.

As part of its GPRA efforts to increase the number of enrollees in the MSP, CMS established a grants program, "Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles." The grants had three major goals:

- to foster partnerships between State, local, and community organizations;
- to increase enrollment of dual eligibles and reduce disparities among subpopulations by addressing identified barriers to participation; and
- to develop and test innovative outreach and enrollment activities that could be replicated in other sites.

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[1] The contract was originally awarded to Health Economics Research, Inc. (HER), which subsequently merged with RTI.

[2] Medicaid also pays the Part A premiums for a small number of QMBs. These are individuals who are required to pay Part A premiums because they do not have sufficient work history to qualify for Social Security.

Description of State Programs

Six States received grants in September 2000 to promote the outreach and enrollment of people eligible for the MSP. These States were: Connecticut, Maryland, Minnesota, Montana, Texas and Washington. The following is an overview of States' plans for their grants.

Connecticut

Connecticut designed five approaches to improve outreach to duals, focusing on Black people, Hispanic people, the homebound and widowed, elderly who live alone and elderly who were near or newly poor. The approaches included direct mailings using AARP letterhead to four Connecticut regions and direct mailings to enrollees in ConnPACE (Connecticut's pharmacy assistance program). Training sessions for professionals about dual eligible programs were conducted by the State's five Area Agencies on Aging (AAAs) to educate professionals who work with low-income Medicare beneficiaries. One of the AAAs piloted an initiative in the greater Hartford area to conduct outreach through places of worship. Lastly, the role of out-stationed Medicaid workers in Federally Qualified Health Centers was expanded to include identifying potential dual eligibles. Through these initiatives, Connecticut hoped to increase enrollment statewide by 14 percent from the baseline.

Maryland

Maryland focused its efforts on increasing awareness and enrollment in four rural regions of the State that had been affected by HMO withdrawals. AAAs in each of the regions hired a staff person to conduct outreach activities and counsel applicants through the process. Marketing materials, such as advertisements, feature stories in newspapers, direct mailings and billboards, were also developed. The State planned to pilot a mail-in application during the course of the grant; however, the pilot did not occur until shortly after the grant ended. Maryland's target was to increase the number of MSP applications by 5 percent over baseline in the four regions.

Minnesota

Minnesota focused its outreach strategy on six rural counties in the State. Many of their strategies were aimed at reducing welfare stigma, which was identified as a significant barrier in rural area. A new, shorter mail-in application was developed. In addition, statewide television and targeted radio advertising campaigns were developed and implemented with assistance from a media consulting firm. When requested by beneficiaries, State workers conducted home visits to discuss enrollment and eligibility. The grant was also used to air public service announcements, advertise through the Meals on Wheels program, and distribute printed material in places of worship, libraries and other public places that elderly frequent. Minnesota's goal was to increase statewide enrollment in the MSP by 20,000 over baseline.

Montana

Montana focused its outreach efforts on beneficiaries in isolated rural areas and on Native American elders. Twenty-three of the grant counties were designated Frontier Counties (less than 2.0 people per square mile), which created a challenge trying to reach eligible beneficiaries. In order to promote the MSP, the State conducted outreach at powwows and fairs. The State also produced a series of informational placemats and a video. The State's goal was to increase enrollment by a minimum of 35 percent over baseline in the grant counties.

Texas

Texas focused its outreach on enrolling eligible but unenrolled Hispanic people who live in colonias along the Texas-Mexico border. Colonias are unincorporated tracts of land, and residents have high levels of poverty, immense health needs and low education levels. Four AAAs were funded to hire and train outreach specialists. The outreach specialists were responsible for, among other things, providing enrollment assistance, conducting presentations, as well as recruiting and training volunteers. Texas aimed to increase enrollment in the regions covered by the participating AAAs by approximately 4 percent compared to baseline.

Washington

Washington's grant grew from the Medicare Savings Coalition, which was formed to examine outreach for dual eligibles in response to a CMS-sponsored Reach-Out Conference. The eight agencies that participated in the grant (out of the 31 in the Medicare Savings Coalition) represented the interests of those living in rural areas, Black people, Hispanic people, Native American people, people from Asia and the Pacific Islands, the disabled, and low-income people. Unlike the other States that had specific enrollment goals, the goal of Washington's project was to implement a structured information gathering process targeted to specific linguistic and cultural subpopulations, in order to develop tailored outreach strategies and promotional materials.

Methodology

The evaluation of the six grant programs had two main components:

(1) case studies of the programs funded under the grants; and

(2) analyses of program enrollment and cost impacts.

The case studies were based on site visits to each State awarded a grant. RTI staff interviewed State officials responsible for developing and administering the grant programs and staff of community organizations operating the programs. In some States we interviewed senior and disabled advocacy groups not directly involved in the grant.

We used Medicaid eligibility data for the grant period and for a baseline period one year prior to the grant to analyze enrollment impacts. Data were analyzed for the areas of the State where grant-funded activities occurred, as well as for a control site within the State (unless the program operated statewide). To the extent they were available, RTI also analyzed tracking data used by the States to monitor and evaluate

their grants. This was intended to provide statistics such as the number of applications distributed, number of applications received, and number of beneficiaries enrolled as a result of the grant initiative. In general, only limited tracking data were available. In addition, each State provided RTI with data on the cost of its outreach and enrollment program.

Enrollment Impacts

Table E-1 shows the change in MSP enrollment from the baseline to the grant period by State. For the four States whose grant initiatives targeted a limited geographic area within the State, we report the enrollment change in the demonstration area only; statewide enrollment changes are reported for the two States whose grants operated statewide.[3] In all States except the two with statewide grants, we identified a control area in order to account for changes in enrollment that would have occurred in the absence of the grant program. The difference between the enrollment change in the control and demonstration area is also reported in Table E-1. This difference is the enrollment change attributed to the effects of the grant program.

Findings on the enrollment impacts of the grant program were somewhat mixed:

- Enrollment in the MSP increased from the baseline to the grant period in the demonstration area in all States with the exception of Maryland.
    - The magnitude of the enrollment increase ranged from 2% (Montana) to 11% (Minnesota).
    - Enrollment fell by 1% in Maryland.
- In all four States where a control group could be defined, the growth in enrollment attributed to the grant was always less than the absolute change from the baseline to the grant period.
    - Minnesota and Texas showed increases in enrollment in the demonstration area compared to the control (4% and 3%, respectively).
    - Maryland and Montana showed declines in demonstration area enrollment compared to control (2% and 1%, respectively).

Our ability to assess the impact of the grants on MSP enrollment was limited in several respects. In those States where the grant operated statewide, there was no control group available that would allow us to account for enrollment changes expected in the absence of the demonstration. Even in those States where a control was available, it was often not ideal. For example, in Maryland and Montana, the demonstration covered much of the rural areas of the State so the control counties were more urban.

[3] In Maryland and Minnesota, most of the grant activities were focused on the demonstration area, but some were also statewide. Enrollment declined by less than 1% statewide in Maryland, while it grew by 7% statewide in Minnesota.

Table E-1 Enrollment Trends by State

STATE	PERCENT CHANGE IN DEMONSTRATION AREA	DIFFERENCE IN PERCENT CHANGE (DEMONSTRATION VS. CONTROL)
Connecticut*	4.7	N/A
Maryland	-1.4	-1.7
Minnesota	11.4	3.5
Montana	2.0	-1.4
Texas	8.1	2.9
Washington*	6.3	N/A

SOURCE: HER analysis of State Medicaid eligibility data.
*The grants in these States operated statewide. Therefore, the figures represent statewide changes in enrollment because no control could be identified.

Cost Effectiveness

Data on the total cost and the cost-effectiveness of the grant programs is summarized in Table E-2. We calculate cost-effectiveness only in States where there was a positive change in enrollment attributed to the grant.[4] In all States except Texas, we calculated cost effectiveness based on the statewide enrollment change.[5] The cost-effectiveness of the grant initiative varied considerably depending on whether it was calculated for the entire state or a limited demonstration area:

- The average cost per person-year of enrollment ranged from $34 to $80 in States where cost-effectiveness was calculated using the statewide enrollment change.
- The average cost per person-year enrolled was $415 in Texas.
- If the cost-effectiveness calculation for Minnesota's program is limited to the demonstration area only, the cost per person-year of enrollment is $369 (data not shown), as compared to $55 when it is calculated statewide.

There are several reasons why cost-effectiveness is so much lower for the programs that were not statewide. First, in the States where we calculate statewide enrollment changes, all growth in enrollment is attributed to the grant as there is no control that could be used to separate the grant impacts from the growth expected otherwise. Because this likely overstates the true impact of the grants, cost-effectiveness calculations based on these estimates of enrollment growth are generous. Second, the program in Texas and the portion of Minnesota's program that was not statewide focused on very rural areas. Given the dispersion of the population, it is more difficult to devise strategies that can efficiently reach large numbers of people.

[4] In States where growth was less than what would have been expected in the absence of the grant (Maryland and Montana), the program was by definition not cost effective.

[5] The grants in both Connecticut and Washington operated statewide. Although portions of Minnesota's grant were targeted to specific demonstration counties, some aspects were statewide.

Table E-2 Cost Effectiveness of State Outreach Programs

STATE	TOTAL COST	INCREASE IN PERSON-YEARS*	COST PER PERSON-YEAR OF ENROLLMENT
Connecticut	$261,202	3,264	$80
Maryland	$221,416	N/A	N/A
Minnesota	$362,329	6,643	$55
Montana	$69,113	N/A	N/A
Texas	$180,279	435	$415
Washington	$195,647	5,710	$34

Source: HER analysis of Medicaid eligibility data and program cost data.
*For all States other than Texas we show the statewide increase in person-years of enrollment from the baseline to the grant period. Therefore, all enrollment growth is attributed to the grant. The increase for Texas is calculated for the demonstration area only and is based on the difference between enrollment growth in the demonstration and control areas.

Success in Achieving Goals of the Grant Program

In this section, we assess the success of the grant programs relative to CMS' three main goals for the initiative.

Fostering Partnerships

The establishment of partnerships was widely viewed as one of the most significant results of the outreach grant and all of the States believed that working through entities with established infrastructures and community ties was essential to conducting outreach for the MSP. States used the grant to strengthen relationships with existing partners, as well as to create new partnerships. For example, two States entered into new partnerships with Federally Qualified Health Centers (FQHCs), which have an established role serving low-income and ethnically diverse populations.

Increasing Enrollment and Reducing Disparities

We have little information on the extent to which the grants successfully reduced enrollment disparities in targeted subpopulations. There is, however, evidence for some States that the grants may have been successful in reaching identified subpopulations. Compared to White people, enrollment increases were greater for Hispanic people in Connecticut and for all racial minorities in Washington. Although data for Montana do not show that the grant had a positive impact on enrollment overall, we did find an increase in enrollment for Native American people, who were a specific focus of the outreach. On the other hand, although Texas' grant targeted the Hispanic community, the increase in enrollment among Hispanic people was no greater in the demonstration counties than in the control counties.

Developing Innovative, Replicable Outreach Strategies

Identifying and enrolling Medicare beneficiaries in the MSP is difficult, as well as time- and resource-intensive. The programs are difficult to describe and understand. The

need for education extends beyond potential eligibles to county workers, health care professionals, aging service providers, and volunteers. Cultural values of self-reliance, an unwillingness to disclose personal circumstances, and a distrust of government are particularly strong in many ethnic communities. The welfare stigma associated with government programs is a significant barrier to enrollment for many elders. Contacting and informing potential beneficiaries about the program is particularly challenging in geographically isolated and sparsely populated regions.

Below, we summarize findings on the effectiveness of some of the strategies adopted in the grant initiatives. These findings are largely drawn from the case study interviews as we have limited quantitative information on the outcomes of specific activities. Most of these strategies are replicable in nearly all States.

- Shortened Applications. Shortened application forms were universally praised. However, collecting the required documentation and completing the application process remained difficult for some elders.
- Assistance with Completing Applications. Although the States that used outreach workers and volunteers to assist beneficiaries in the application process considered this strategy critical to ensuring that the application was completed, it is labor intensive and time consuming. Its effectiveness was somewhat limited because this assistance does not always continue through the entire application review process. This can be addressed by allowing surrogates both to assist in completing the application and to act as representatives that can receive all information regarding the application and re-enrollment.
- Door-to-Door Outreach. This strategy can be effective for reaching potential eligibles (e.g., the homebound), who are not likely to attend settings where mass outreach, such as group presentations, is conducted. It also provides an opportunity to assist with completing the application. However, it is an expensive and time-consuming strategy.
- Tailored Printed Materials. Each of the States considered it important to develop materials that were culturally sensitive to the specific population being targeted and that described the programs in simple, catchy terms.
- Direct Mailings. Direct mailing can be an effective strategy if it is targeted to people who are likely to be eligible, for example, enrollees in other public assistance programs with similar eligibility requirements. Poorly targeted mailings can be confusing and alienating to recipients. Direct mailings can also create confusion among recipients that are already enrolled in the MSP because they may think that they need to re-enroll to retain their benefits.
- Piggybacking on Prescription Drug Programs. Two States piggybacked outreach for the MSP on their prescription drug programs, taking advantage of the popularity of these programs. The MSP was marketed as a complement Medicare and drug program benefits. While one State found this an effective strategy, it was considered less effective in the other State, perhaps because the MSP is subject to estate recovery, while the prescription drug program is not.

- Use of the Media. The effectiveness of mass media-based outreach strategies varied. One State used a paid television ad campaign. The State viewed the ads as ineffective because there was not sufficient financing for a saturation campaign or advertisements targeted solely at the MSP. Nonetheless, a survey of MSP beneficiaries in that State identified television as the best way to reach them with information on the MSP. In contrast, another State, which relied on free appearances on radio and television programs, viewed the media as one of the most effective vehicles for reaching people in the rural, geographically dispersed areas targeted in its grant.

Enrollment Barriers Not Addressed by the Grants

States and their partners identified remaining policy barriers to enrollment of duals into the MSP that could not be addressed by interventions, such as those under the grant program, designed to improve or target outreach. The barriers include:

- estate recovery;
- asset limits;
- limitations on reimbursement of Medicare cost sharing payments; and
- very limited benefits under the QI-2 program.

Study Limitations

There were a number of limitations on our ability to fully evaluate the impact of these grant programs. Among the problems were the absence of an adequate control in most States and the lack of data that directly tracked activities under the grants and their outcomes. As a result, it was difficult to accurately measure enrollment impacts.

In addition, the time period for this grant was likely too short to effectively implement some of the outreach efforts and to measure their impacts. Many of the States did not begin their outreach activities until the initial grant year was well underway. Despite a 3-month extension of the grant, certain activities that required substantial development did not begin until close to the end of the grant period. Therefore, increases in enrollment that might be attributable to the grant would not be observed until late in the grant period or after it was over. Furthermore, some of these activities were viewed as long-run investments where the returns would not necessarily be felt immediately. Future studies should follow out program impacts over a longer period of time.

While the great majority of efforts in this grant were channeled towards outreach and enrollment of new potentially eligible elders into the MSP, some of our case study findings suggest that the complexities of the recertification process remain a barrier to continuous enrollment. Thus, maintaining enrollment is as important as attracting new enrollees if the program is to be successful. While this evaluation was not designed to address continuity of enrollment, other work under this contract to evaluate the QMB and SLMB programs will examine duration of program enrollment.

CHAPTER 1
OVERVIEW OF REPORT

RTI International[1] was awarded a contract from the Centers for Medicare & Medicaid Services (CMS) to conduct an evaluation of grant programs in six States that received funding to promote outreach and enrollment in the Medicare Savings Programs (MSP). The following chapter provides the background for these grants and the MSP, as well as an overview of the methodology for this evaluation and an outline for the rest of the report.

1.1 Introduction

1.1.1 Description of the Medicare Savings Programs

The MSP consist of five programs:

- Qualified Medicare Beneficiaries (QMB);
- Specified Low-Income Medicare Beneficiaries (SLMB);
- Qualified Individuals I (QI-1);
- Qualified Individuals II (QI-2); and
- Qualified Disabled Working Individuals (QDWI).

Medicaid assists enrollees in these five programs in paying for their Medicare premiums and, in some cases, their deductibles and coinsurance.

The QMB program was created under the Medicare Catastrophic Coverage Act (MCCA) of 1988, which mandated Medicaid coverage of Medicare cost-sharing requirements for Medicare beneficiaries with incomes up to 100 percent of the federal poverty level (FPL) and resources not in excess of twice the SSI resource limit. Medicaid pays the Medicare Part B premiums for QMB enrollees, as well as their deductibles and coinsurance.[2] Under earlier provisions of the Omnibus Reconciliation Act of 1986 (OBRA 86), States also have the option of providing full Medicaid benefits to Medicare beneficiaries with incomes up to 100 percent of FPL and resources not in excess of the SSI resource level (Carpenter, 1998). Ten States and the District of Columbia exercise this option (Rosenbach and Lamphere, 1999).[3] Beginning in 1993, the SLMB program expanded these protections by mandating Medicaid coverage of Part B premiums for Medicare beneficiaries with incomes up to 120 percent of FPL and resources that do not exceed two times the SSI limit.

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[1] The contract was originally awarded to Health Economics Research, Inc. (RTI), which subsequently merged with RTI.

[2] Medicaid also pays the Part A premiums for a small number of QMBS. These are individuals who are required to pay Part A premiums because they do not have sufficient work history to qualify for Social Security.

[3] The ten States are: Hawaii, Maine, Massachusetts, Mississippi, Nebraska, New Jersey, Pennsylvania, South Carolina, Utah and Vermont. In addition, Florida extends full Medicaid benefits to Medicare beneficiaries with incomes up to 90 percent of FPL.

Several other categories of dual eligibles have also been created during the past decade, including Qualifying Individuals (I) and (II) (QI-1s and QI-2s) and Qualified and Disabled Working Individuals (QDWIs). QI-1s have incomes of 120-135 percent of FPL, QI-2s have incomes up to 175 percent of FPL, and QDWIs are people that have lost their Medicare Part A benefits as a result of returning to work and have incomes up to 200 percent of FPL. Beneficiaries in all three categories are allowed resources up to two times the SSI limit. Like SLMBs, Medicaid reimburses only the Part B premiums for QI-1s. QI-2s are reimbursed a small amount to make up for annual Part B premium increases ($3.91 per month in 2002). Medicaid pays the Medicare Part A premiums for QDWIs. The QI and QDWI programs enroll very small numbers of beneficiaries.

Even prior to the legislation that created the QMB and SLMB programs, dual Medicare-Medicaid eligibility has always been extended to certain categories of low-income Medicare beneficiaries. States must provide full Medicaid benefits to recipients of Supplemental Security Income (SSI), including coverage of Medicare's cost-sharing requirements and coverage of Medicaid services that are not included in the Medicare benefit package. States also have the option of providing Medicaid coverage to Medically Needy beneficiaries whose income and assets exceed SSI criteria, but who incur catastrophic medical expenses. Current, 34 States and the District of Columbia operate Medically Needy programs (Rosenbach and Lamphere, 1999).

The distinction among the various categories of dual eligibles was blurred by the Technical and Miscellaneous Revenue Act of 1998, which changed the definition of QMBs to include anyone meeting QMB requirements even if they are otherwise eligible for Medicaid (Carpenter, 1998). Thus, all SSI recipients and some Medically Needy eligibles are classified as QMBs. Under this definition, the QMB category includes both dual eligibles receiving full Medicaid benefits and those whose coverage is limited to Medicare cost sharing. Similarly, the SLMB category may encompass some full-benefit Medically Needy eligibles, as well as those eligible only for coverage of Part B premiums. CMS distinguishes these groups by differentiating between QMB-Plus and SLMB-Plus (full-benefit dual eligibles) and QMB-Only and SLMB-Only (duals eligible for coverage of Medicare cost sharing and/or premiums only).

1.1.2 MSP Participation Rates

Numerous studies have shown that large numbers of potentially eligible QMBs and SLMBs do not participate in these programs. Most studies have found that somewhere around half of all potential QMB/SLMB eligibles are not enrolled, with estimates ranging from 42 percent to 53 percent for time periods ranging from 1993 to 1996 (Barents Group, 1999; GAO, 1999; Rosenbach and Lamphere, 1999; Families USA, 1998; Moon *et al.*, 1996). A more recent estimate for 1998 found higher enrollment rates, with only 36 percent for QMB/SLMB eligibles not enrolled (Moon *et al.*, 1998). Participation rates vary markedly across the QMB and SLMB programs. QMB participation rates range from as low as 41 percent (Neumann *et al.*, 1995) to as high as 78 percent (Moon *et al.*, 1998), while estimated SLMB participation rates are far lower, ranging from 0.5 percent to 16 percent (Barents Group, 1999; Moon *et al.*, 1998; Moon *et al.*, 1996; Families USA; 1993). Moreover, there is substantial variation across States in participation rates (Rosenbach and Lamphere, 1999; Families USA, 1998). Despite their lack of

uniformity, all of these estimates indicate that large numbers of potential eligibles are not taking advantage of QMB/SLMB benefits.

Among the factors that have been identified as possible determinants of success in enrolling QMB/SLMB beneficiaries are State outreach activities, simplified application processes, and generosity of Medicaid eligibility standards (Walsh, *et al.,* 2001; Rosenbach and Lamphere, 1999; Nemore, 1997). However, previous research has yielded little evidence of an association between intensity of outreach activities and participation rates (GAO, 1994; Shaner, 1999). This report provides an evaluation of programs in six States that received grants to perform outreach for the MSP and analyzes the relationship between these outreach activities and enrollment.

1.1.3 Overview of the Grants

Under the Government Performance and Results Act (GPRA), one of CMS' initiatives is to identify and enroll more dual eligibles into the MSP. As part of its GPRA efforts, CMS established a grants program, "Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles." The grants had three major goals:

- to foster partnerships between State, local, and community organizations;
- to increase enrollment of dual eligibles and reduce disparities among subpopulations by addressing identified barriers to participation; and
- to develop and test innovative outreach and enrollment activities that could be replicated in other sites.

In September 2000 six States – Connecticut, Maryland, Minnesota, Montana, Texas and Washington – were awarded grants to fund their proposals. The grant period was originally from October 2000 through September 2001, but subsequently it was extended an additional three months. However, not all States took advantage of the additional time. The following is an overview of States' plans for their grants.

Connecticut

Connecticut designed five approaches to improve outreach to duals, while focusing on Black people, Hispanic people, the homebound and widowed, elderly who lived alone and elderly who were near or newly poor. The approaches included direct mailings with the AARP logo on the letterhead to four Connecticut regions and direct mailings to enrollees in ConnPACE (Connecticut's pharmacy assistance program). Both direct mailings were conducted in partnership with the AARP, Division of Social Services, Medicaid and the Area Agencies on Aging (AAAs). Five training sessions about dual eligible programs were conducted by the AAAs to train professionals who work with low-income Medicare beneficiaries. The North Central Area Agency on Aging of Connecticut partnered with religious groups to reach duals through their places of worship (this pilot was in the greater Hartford area only). Lastly, the role of out-stationed Medicaid workers was expanded to include identifying people who may be dual eligibles. Through these initiatives, Connecticut hoped to increase MSP enrollment by 14% statewide, from 50,000 to 57,000.

Maryland

Maryland focused its efforts on increasing awareness and enrollment in four rural regions of the State that had been affected by HMO withdrawals. AAAs in each of the regions hired a staff person to conduct outreach activities and counsel applicants through the process. Marketing materials, such as advertisements, feature stories in newspapers, direct mailings and billboards were also developed. The State planned to pilot a mail-in application during the course of the grant; however, the pilot did not occur until shortly after the grant ended. Maryland's target was to increase the number of MSP applications in the four regions targeted by the grant by 5 percent compared to the previous year.[4]

Minnesota

Minnesota focused its outreach strategy on six rural counties in the State. According to the State, there were approximately 42,000 eligible but unenrolled beneficiaries, half of whom resided in rural areas. Because Minnesota discovered that there was a great deal of welfare stigma in the rural areas, many of their strategies were aimed at reducing this barrier. A new, shorter mail-in application was developed. At the request of beneficiaries, State workers conducted home visits to discuss enrollment and eligibility. The grant was also used to air public service announcements, advertise through the Meals on Wheels program and distribute printed material in places of worship, libraries and other public places that elderly frequent. Minnesota's goal was to increase enrollment in the MSP by 20,000 Statewide. Prior to the grant, Minnesota enrolled approximately 62,000 beneficiaries in the MSP.

Montana

Montana focused its outreach efforts on beneficiaries in isolated rural areas and on Native American elders. Twenty-three of the grant counties were designated Frontier Counties (less than 2.0 people per square mile), which created a challenge trying to reach eligible beneficiaries. In order to promote the MSP, the State conducted outreach at powwows and fairs. The State also produced a series of informational placemats and a video. The State's goal was to increase enrollment by a minimum of 35 percent in the grant counties. Prior to the grant, there were approximately 5,700 beneficiaries enrolled in MSP in these counties.

Texas

Texas focused its outreach on enrolling eligible but unenrolled Hispanic people who live in colonias along the Texas-Mexico border. Colonias are unincorporated tracts of land. Residents of colonias have high levels of poverty, immense health needs and low education levels. Four AAAs in El Paso, Laredo, McAllen and Carizzo Springs were funded to hire and train outreach specialists. The outreach specialists were responsible for, among other things, providing enrollment assistance, conducting presentations, recruiting and training volunteers. Texas aimed to have approximately a 4 percent increase in enrollment in the regions covered by

[4] The State's grant application did not provide information on baseline enrollment in the demonstration area. Based on RTI's analysis of Maryland's Medicaid eligibility data, there were 17,944 person years of coverage for dual eligibles in the demonstration area between October 1999 and September 2000.

the participating AAAs. Texas reported baseline enrollment of approximately 15,000 dual eligibles in the demonstration area.[5]

Washington

In response to CMS' San Francisco Reach-Out Conference, the Medicare Savings Coalition in Washington was formed to examine outreach for dual eligibles. It includes 31 agencies, eight of which participated in this grant. The participating agencies represented the interests of those living in rural areas, Hispanic people, Native American people, the disabled, low-income people, Black people, and Asian-Pacific Islanders. Unlike the other states that had specific enrollment goals, the goal of the project was to implement a structured information gathering process targeted to specific linguistic and cultural subpopulations, in order to develop outreach strategies that would be effective for each subpopulation. Specifically, this information was to be used to tailor the outreach material provided in the CMS "Outreach Kit," and to develop a brochure for statewide use.

1.2 Methodology

The evaluation of the six grant programs addresses the following broad issues:

- the impact of the program on enrollment of dual eligibles;
- the impact of the program on barriers to enrollment and disparities among subpopulations;
- the effectiveness of partnerships; and
- the effectiveness of outreach and enrollment activities.

The evaluation has two main components:
(1) case studies of the programs funded under the grants; and
(2) analyses of program enrollment and cost impacts.

1.2.1 Case Studies

The case studies were based on site visits to each State awarded a grant. The six site visits were conducted between May 2001 and September 2001. RTI staff interviewed State officials responsible for developing and administering the grant programs and staff of community organizations operating the programs. In some States we interviewed senior and disabled advocacy groups not involved in the grant to learn how they viewed the programs. The appropriate informants were identified through discussions with State staff responsible for administering the grants.

The interviews included the following topics: program origins; program design, organization and implementation; enrollment process; outreach strategies; program impacts, successes and failures; and lessons learned. We gathered information about these issues for both

[5] Texas's grant application reported 13,146 Hispanic dual eligibles in the demonstration area as of June 2000. RTI's analysis of baseline eligibility data found that 88 percent of dual eligibles in the demonstration area were Hispanic. This factor was applied the number of Hispanic dual eligibles reported estimate the total number of dual eligibles in the baseline period.

the pre-grant period as well as the grant period in order to examine how processes and strategies changed due to the grant. A copy of the protocol is included in Appendix A.

1.2.2 Medicaid Eligibility Data

The analyses of enrollment impacts were based on secondary data reported by the States. All States submitted to RTI Medicaid eligibility data for the pre-grant period (October 1999 - September 2000) and the grant period (October 2000-September 2001 or December 2001, depending on whether the State took advantage of the extension of the grant period). Medicaid eligibility files provided information on the number of enrollees, as well as beneficiary characteristics and type of program. Data were analyzed for the areas of the State where grant-funded activities occurred (demonstration areas), as well as for control sites within the State (unless the program operated statewide). With assistance from the States, we chose control areas with similar geographic and demographic characteristics to the demonstration areas. Each state provided RTI with monthly eligibility files, from which we calculated the number of enrollees per month. We calculated the number of person-years of enrollment by dividing the sum of monthly enrollments by the number of months in the study period (12 months for the baseline period and for the grant period in states that did not take advantage of the grant extension; 15 months for the grant period in states that extended the grant period). This annualized count provides a measure that is invariant to differences in the length of the study periods. We also calculated the number of unique individuals covered in the baseline and grant periods. Because this statistic cannot be annualized, these numbers are not comparable in States with a 15-month grant period.

Using the Medicaid eligibility data, we calculated the percent change in the number of person years of enrollment between the baseline and grant periods for the demonstration and control sites. Where State activities varied by region, we also calculated percent change by region within the demonstration area. Overall percent change is reported, as well as percent change by age, gender, racial and ethnic group, urban versus rural area of residence[6] and by program eligibility. We cross-walked eligibility categories reported in each State's Medicaid files into dual eligibility program categories with assistance from each State. The main categories used in our analyses are SSI, QMB, SLMB, and Medically Needy.[7] The Medicaid eligibility files in most of our study states did not include QI-1, QI-2, or QDWI eligibles. Where the data were available, we report enrollment in these categories also. We also calculated the difference in percent change between the demonstration and control group sites. This number provides a measure of the impact of the grant program on enrollment, assuming enrollment changes in the control site are a reasonable indicator of expected enrollment changes in the demonstration area in the absence of the grant program. If the difference in percent change is

[6] Counties were classified as urban or rural using CMS' Metropolitan Statistical Area Bureau of Economic Analysis (MSABEA) file, "SSA and FIPS State and County Crosswalk Developed for the Prospective Payment System."

[7] As described previously, SSI and Medically Needy beneficiaries are now also classified as QMBs and SLMBs, although the SSI and Medically Needy dual eligibility categories have existed since the beginning of the Medicare and Medicaid programs. We separated these categories in our analyses in order to distinguish them from the QMB and SLMB beneficiaries that are eligible under the coverage expansions of the 1980s and 1990s. In addition, SSI and Medically Needy beneficiaries receive full Medicaid benefits while those that classified as QMBs and SLMBs in our analyses receive only Medicare cost sharing benefits.

positive, it indicates that the demonstration program had a positive impact on enrollment; if negative, enrollment growth in the control area was higher than in the demonstration area.

We also used the Medicaid eligibility data to calculate month-by-month trends in enrollment in order to examine whether the timing of enrollment increases corresponded to initiation of outreach activities under the grant. In addition, these monthly trend data allow us to identify any changes in the pattern of enrollment growth between the baseline and grant period.

We do not report tests of significance for any of the statistics calculated. Significance testing is not required because we analyzed the entire population of enrollees. As a result, it is more meaningful to ask whether the magnitude of the effect identified is of policy significance.

1.2.3 Tracking Data

RTI requested that all States provide us with any tracking data that they used to monitor and evaluate their grants. This was intended to provide statistics such as the number of applications distributed, number of applications received, and number of beneficiaries enrolled as a result of the grant initiative. Unlike administrative eligibility data, this tracking data has the advantage of directly linking applicants to grant-funded outreach and enrollment activities. This may be important if States have outreach activities operating concurrently outside of the grant that could affect enrollment. However, tracking data cannot be used to identify the impact of more generalized publicity activities incorporated in some States' grant programs, which do not involve the direct distribution of an application or a one-on-one contact. In addition, tracking data do not allow us to control for overall trends in the MSP enrollment in a State that could have spillover effects on the impact of grant-funded outreach and enrollment activities. Hence, if we had program-specific tracking data, we used it to supplement, but not replace, our analysis of eligibility files. Unfortunately, not all States tracked applicants based on specific activities conducted through the grant.

1.2.4 Cost Data

Each State provided RTI with data on the cost of their outreach and enrollment program. States were asked to report total program costs, as well as costs broken into State and Federal shares. States that had grant programs with multiple components were asked to report cost data separately by component. These data were to be used in conjunction with eligibility and tracking data to evaluate the cost-effectiveness of the outreach programs. Due to the quality of the tracking data received, RTI was not able to analyze the cost-effectiveness of the programs in every State using tracking data.

1.3 Overview of Report

This report contains seven additional chapters. Six chapters describe the evaluation of the States' programs, one chapter for each State. Each chapter provides the following:

- Overview and background of the grant;
- A description of the implementation and operation of the grant;
- Analyses of program enrollment and cost impacts using tracking data, Medicaid eligibility data and cost data; and

CHAPTER 2
CONNECTICUT

2.1 Program Overview and Background

For this grant Connecticut adopted five approaches to improve outreach to dual eligibles and increase enrollment in the MSP. The State focused on several vulnerable populations including Black people, Hispanics, the homebound, widowed elderly and elderly who were near or newly poor. The approaches included:

- outreach to religious institutions by Area Agencies on Aging (AAAs) in the Greater Hartford area;
- training of professionals in full-day sessions throughout the State;
- direct mail campaign using listings of American Association of Retired Persons (AARP) members;
- direct mail campaign to enrollees in ConnPACE (the State's prescription drug assistance program); and
- using outstationed Medicaid outreach workers at 12 federally qualified health centers (FQHCs) to conduct MSP outreach.

A number of partners were involved in the outreach efforts: the Department of Social Services, the Connecticut Primary Care Association, the Center for Medicare Advocacy, AAAs and the AARP. All partners except AARP had a contractual arrangement with Department of Social Services and received financial support through the grant. The Elderly Services and Medicaid Divisions within DSS were instrumental in overseeing and facilitating the grant activities. The Connecticut Primary Care Association had MSP-trained outreach workers stationed in FQHCs to accept applications. All of the State's AAAs participated in professional training and provided support for the MSP applicants through the AAA-based CHOICES counseling program. In addition, the North Central AAA (NCAAA) had an initiative to perform outreach to churches and other religious institutions. The Center for Medicare Advocacy, a private, non-profit organization that provides education, advocacy, and legal assistance to elders and people with disabilities, produced training materials on the MSP. AARP was responsible for one of the direct mailing campaigns.

Connecticut pursued this grant because it wanted to build on previous successful outreach activities designed to enroll dual eligibles in the MSP. A major step towards increasing enrollment in the MSP was the introduction of a new, shorter application form in October 1999, a copy of which can be found in Appendix B. They also eliminated the requirement for a face-to-face interview and allowed mailed applications. Documentation requirements were also waived. These innovations were followed by an outreach campaign that included mailings to various agencies and professionals. After the new simplified application form was developed, a mailing of 16,000 applications was sent to AAAs, adult day care centers, senior centers,

municipal agents, home health agencies and hospital discharge workers to distribute to potential eligibles.

Additional pre-grant efforts included a direct mailing to Medicare beneficiaries using Leads Data[1] and a direct mailing to residents in the Hartford area with the cooperation of AARP. These initiatives resulted in more than 900 applications. In addition, the CHOICES program, together with the Center for Medicare Advocacy (CMA), developed and piloted a training session for professionals that were run by CHOICES volunteers. CHOICES programs included a segment on the MSP during their various presentations. AAAs presented at health fairs and at various locations frequented by seniors and participated in radio interviews to promote the MSP. Additionally, materials were developed by DSS to explain and promote the MSP.

The State hoped to expand these initiatives to further increase enrollment. The grant was also perceived as an opportunity to forge closer ties among different DSS departments, such as Elder Services and Medicaid, and with other organizations, such as AARP and AAAs. In addition, DSS planned to establish a relationship with the Connecticut Primary Care Association.

Connecticut's goal was to increase enrollment in the MSP by 14%, from 50,000 to 57,000 dual eligibles. A second goal was to strengthen existing partnerships and foster lasting relationships among the partners. The following goals were set for individual initiatives:

- 2,000 applications were expected to be received from the AARP mailing;
- 1,000 applications were expected as a result of the mailing to ConnPACE recipients;
- five professional training sessions of about 40 persons per region were expected to be completed by March 31, 2001, resulting in 2,000 applications;
- about 800 applications were expected as a result of outreach to churches; and
- about 1,200 applications were expected from the expansion of Medicaid outreach workers' roles at 12 FQHCs (100 applications per center).

The State's outreach initiatives were designed to address some of the barriers to enrollment in the MSP identified prior to the grant. Lack of knowledge and understanding of the MSP and Medicare benefits in general was pervasive both among potential beneficiaries, as well as among health care and aging network providers and regional DSS staff.[2] Information on eligibility criteria changes was hard to obtain and keep current. There was a vast amount of misinformation about the MSP. DSS staff in regional offices were not appropriately trained about the MSP, and substantial staff turnover among intake workers made it difficult to provide adequate training.

[1] Leads Data are produced by the Social Security Administration to inform the State of newly enrolled Medicare beneficiaries.

[2] Connecticut DSS offices are based on regions and not counties.

Personal perceptions of the elderly were also identified as barriers. There was a stigma associated with all State means-tested programs that is difficult to overcome. Individuals were reluctant to admit that they needed help, were reluctant to divulge personal information, feared that applying for the MSP would jeopardize other benefits, and often had a general mistrust of government agencies. Those who had experienced a rejection of Medicaid applications in the past were also reluctant to apply for assistance.

Additionally, with aging of the immigrant population, AAAs saw a greater need to conduct outreach to various ethnic communities. However, reaching out to immigrant populations proved difficult given the shortage of qualified bilingual staff and volunteers. While most AAA's are able to recruit Spanish-speaking staff, conducting outreach in other languages is challenging.

Compared to other States, Connecticut has more generous income limits for the MSP and a higher income disregard ($183 per person).[3] Nonetheless, a number of financially-related barriers to MSP enrollment were identified during the site visit, including Medicare cost-sharing, estate recovery, and asset limits. These barriers were not directly addressed by the grant program.

In 1999 Connecticut adopted a law limiting Medicaid's coverage of Medicare cost sharing payments if the amount reimbursed by Medicare exceeds the Medicaid reimbursement for that service. Since Medicare reimbursement usually exceeds Medicaid, Connecticut's Medicaid program often does not make any cost sharing payments for QMBs other than the Part B premium and the Part A and Part B deductibles. This policy change could decrease the incentive to enroll in MSP in two ways. First, to the extent that the QMB benefit is reduced to covering premiums and deductibles only, the program is less attractive than it is in states with no cost-sharing limit. Second, if the cost-sharing limit reduces the willingness of providers to accept dual eligible patients, enrolling in the QMB program could actually jeopardize access to care.

Informants reported that this change produced significant access problems for QMBs, especially in rural areas, because physicians are reluctant to absorb the cost-sharing payment as a financial loss. According to our interviews, access to specialists and to mental health providers is especially problematic. Interviewees reported that most physicians will not drop existing patients, but they are reluctant to accept new dual eligible patients. Duals who have been 'orphaned' due to HMO withdrawals also have difficulty finding new physicians.

While information gathered during the site visit interviews is anecdotal by nature, advocates voiced many concerns about cost-sharing payment limitations. For example, one AAA reported that some physicians bill QMBs for the cost-sharing amount, although it is illegal. There were also reports that QMBs pay the 20% copayment quietly "under the table" in order to continue receiving care from physicians of their choice.

[3] Income limits for MSP in Connecticut effective April 1, 2002 are: QMB $922.00 single, $1,361.00 couple; SLMB $1,069.80 single, $1,560.00 couple. The income disregard is $183 per person.

CHOICES counselors in Connecticut have developed a statewide strategy for advising elders on how to deal with this problem. They inform them that the combination of Medicare, ConnPACE and QMB provides adequate coverage. Some CHOICES counselors advise elders to retain their MediGap coverage to ensure access to physicians and to apply the $50 they receive for the Part B premium from their QMB benefit to help pay for MediGap premiums.

Estate recovery is another large barrier. Although Connecticut waived estate recovery for ConnPACE, making it a more attractive program for low-income elders, this has not been done for MSP. CHOICES counselors are obligated to inform beneficiaries about estate recovery and they report this discourages many people from applying or even requesting information about the program.

Asset limits present an additional barrier. Although Connecticut eliminated asset limits for the QI-1 and QI-2 programs effective April 1, 2002, the asset limits were not increased for other MSPs, still precluding eligibility for many people, especially those in rural parts of the State that own land. This creates a substantial gap for people who are still too poor to afford MediGap coverage, but not poor enough to qualify for the MSP. There was also a general feeling that the benefits in some programs were not worth the trouble of the application process (for example, the QI-2 program, which only provides $3.09 per month).[4] As one potential eligible suggested, "three bucks is not worth having your name on a welfare roll."

The recertification process was identified as a barrier to continuous participation since the re-certification form had not yet been upgraded at the time of the site visit to a simpler format consistent with the new, shorter application. The re-certification form was longer than original application and asked many questions that people found unsettling, such as questions about education.[5] Also, many people miss or do not understand the recertification notification letter, which is long and complicated.

2.2 Program Implementation and Operation

Connecticut's program consisted of the five initiatives, each of which is discussed in turn.

1. North Central AAA (NCAAA) Outreach to Places of Worship

This initiative consisted of contacting churches and church associations with offers of program information, as well as opportunities to host workshops and recruit volunteers for the CHOICES program. Places of worship were chosen because they can provide a needed link to isolated elders who do not visit senior centers and who are not enrolled in other programs.

January 2000 was the official start for this initiative. However, the decision was made to wait until the new income guidelines were published in April for 2000. Four hundred places of

[4] This amount was increased to $3.91 in 2002.

[5] Since the site visit, Connecticut has adopted a shortened 4-page recertification form, which is identical to the application form, but has a different title.

worship in the area were identified. In addition, cover letters were sent in both English and Spanish, together with brochures for distribution and inserts for church bulletins. Materials included a State-developed package with application forms and cover letters with local contact information and telephone numbers.

NCAAA targeted several towns for intensive effort. In these towns, NCAAA tried to identify the community outreach person at each place of worship. Where possible NCAAA mailed out personalized, instead of generic "to whom it may concern", letters to church contacts, as well as followed up with a phone call, allowing for a dialog with church staff. Once the contact was established, NCAAA offered to send more materials or give a presentation. However, they could not identify contact names in many institutions. Overall, 400 letters were mailed to churches and other religious institutions in the area, which resulted in 112 follow-up calls. Fifty-two churches requested additional information. As a result of the follow-up calls, 1 presentation was delivered by NCAAA staff.

2. Training of Professionals

This initiative was developed by DSS and CMA. The primary goal was to educate professionals in the aging service delivery network about the MSP and distribute information packages developed by DSS and CMA. The second goal was to facilitate interaction between various agencies and foster future communication and cooperation.

The sessions had two basic components: information and brainstorming. In the first part, participants received updates and comprehensive information about the MSP. Updates on policy changes such as asset limits, income guidelines, and verification of income were provided. Then participants were invited to identify barriers preventing enrollment in the programs, as well as to develop innovative approaches and outreach activities for accessing difficult to reach populations. The brainstorming session was a key component of the training program and encouraged participants to develop outreach ideas that could be applied in other regions or that DSS could use throughout the State.

Each region was responsible for one full-day training session. Professionals attending the training sessions included staff from senior centers, aging network professionals, staff from home health agencies, municipal agents, hospital discharge planners and town social workers. Community mental health professionals, community health centers staff and outreach workers from FQHCs were invited, as were representatives from related non-profit agencies.

The goal for this initiative was to train about 200 people (40 people in each of the 5 AAA regions). The State trained 178 individuals, 134 of whom submitted very positive evaluations of the training.

3. Direct Mailings with AARP Listings

This initiative involved a mass mailing campaign to beneficiaries using the AARP member mailing list. Packets with an information booklet, application form and a letter were

sent to Medicare beneficiaries enrolled in AARP. AARP purchased zip code information to identify low-income areas in order to target the mailing to areas likely to have a higher concentration of potential eligibles. Generally, this initiative was deemed not very successful. Overall, 36,000 letters were mailed and 396 applications were submitted as a result (a response rate of 1%).

4. Direct Mailing to ConnPACE Recipients

This initiative involved direct mailing to all recipients of ConnPACE, Connecticut's prescription drug program. Like the previously discussed initiative, this mailing was conducted in cooperation with AARP. In order to mitigate the distrust associated with government programs, the mailing used AARP letterhead and was signed by the AARP National Executive Director. DSS thought that there would be a better response to the letter if it came from AARP rather than from the State DSS.

The ConnPACE and MSP programs have similar income limits, so that most ConnPACE recipients are potentially eligible for MSP. However, unlike QMB and SLMB, the ConnPACE program does not have an asset limit or estate recovery. With CMS' agreement, the mailing started later than originally planned in order to wait for implementation of the asset limit waiver for QI programs, which allowed many more people to become eligible for this limited benefit.

DSS expected about 1,000 MSP applications in response to the initiative, but received 5,238. The response was so powerful that the regional DSS offices that process applications were flooded with paperwork and were unable to process applications within the state-required 45 days. DSS regional offices had to scramble to put additional staff into processing applications, which was problematic since these staff were not fully trained in the MSP programs. Because of the higher than expected response, the state was not able to track the outcome of these applications. Therefore, it is not known how many of the applicants were not already enrolled in the MSP and how many were ultimately eligible.

5. Outreach through FQHCs

Twelve FQHCs contracted with the Connecticut Primary Care Association to participate in this grant. The purpose of this initiative was to utilize Medicaid outreach workers with close ties to local ethnic and racial communities and provide them with training to reach out to dual eligibles. While FQHCs routinely provide outreach about Medicaid and SCHIP to their clients, they typically focus on non-elderly populations and were not familiar with the MSP. Outreach workers joined other professionals for a full-day training session for professionals run by the AAAs. Outreach workers at each FQHC then developed their own outreach activities for the MSP and assisted beneficiaries in completing the application process. FQHC outreach and enrollment assistance took place during the last two quarters of the grant.

Each FQHC was expected to undertake six outreach activities. A total of 126 outreach activities were conducted by the 12 FQHCs over the course of the two final quarters of the grant, which was 54 more than was required. Outreach activities included: presentations in local senior centers or in elderly housing complexes; advertisements in local newsletters; assessing eligibility for existing elderly health center clients; and reaching out to vision-impaired and disabled

clients, and to grandparents of children on Medicaid. A key activity by Medicaid outreach workers was making door-to-door home visits to inform their clients of the MSP. Home visits were effective because they allowed workers to complete applications after determining whether the client was eligible. However, they were expensive and time-consuming.

The goal of this initiative was to generate 100 applications per center, 1,200 in total. However, only 209 applications were received from FQHCs after the training session. While the number of applications was far smaller than the 1,200 that had been set as a goal, this effort was perceived to have created a useful and lasting connection between the health centers and DSS.

2.3 Program Enrollment Impacts and Costs

Tracking Data

Connecticut tracked the number of applications generated by most of its initiatives. However, with the exception of the FQHC initiative, the outcome of these applications was not tracked. As a result of the direct mailing initiative with AARP, 396 applications were received. The ConnPACE campaign yielded 5,238 applications, more than five times the expected return rate. Applications and enrollment resulting from the NCAAA initiative were not tracked, but it is unlikely that the goal of 800 applications was met given the poor response by houses of worship. There was also no effort to track applications associated with the professional training.

For the FQHC initiative, applications were tracked before and after the outreach workers attended training sessions for professionals. During a six-month period prior to the MSP training, the outreach workers processed 56 applications for the dual eligible programs. During the six-month period following the training, the health centers processed 209 applications. Although the overall goal of receiving 1,200 applications was not achieved, the number of applications quadrupled after outreach workers attended the training, demonstrating a positive trend and the effectiveness of educating them about the MSP. The table below exhibits the enrollment status of applications received from FQHCs in the last two grant quarters by the program type:

Table 2-1
Applications Received During the Last Two Quarters of the FQHC Initiative

# Enrolled in QMB	37
# Enrolled in SLMB	15
# Enrolled in QI-1	13
# Enrolled in QI-2	12
# Enrolled in Other Medicaid-related programs (i.e., Medicaid spend-down)	67
# Pending app/ Incomplete app	23
# Require further investigation by DSS: some may be ineligible	42
Total # applications received	209

Source: Connecticut Department of Social Services: Final Program Report 12/31/01

Medicaid Eligibility Data

We analyzed enrollment trends for a 24-month period (October 1999 through September 2001) using eligibility data supplied by the state. The baseline period consisted of the 12 months prior to the grant period (October 1999 through September 2000). Connecticut did not take advantage of the opportunity to extend the grant period for an additional 3 months. Therefore, the grant period reflects the twelve months from October 2000 through September 2001. The program eligibility codes in Connecticut Medicaid eligibility files do not distinguish between the various programs where beneficiaries receive full Medicaid benefits. As a result, all beneficiaries with SSI, long term care, and home and community based service (SSI/LTC/HCBS) program eligibility codes were grouped for analysis into a single category.

The table presenting statewide enrollment changes (Table 2-2) is organized as follows. The first two columns show the percent distribution within each category (e.g., gender, age, and race) for the baseline and grant periods, respectively. For example, in the baseline period 37.8% of the dual eligibles were under 65 years of age, whereas 39.8 % of dual eligibles fell in this age group during the grant period. The third column shows the percent change in enrollment from the baseline to the grant period for dual eligibles overall and for subcategories of eligibles. For example, in the under 65 age group there were 26,342 person-years of enrollment during the baseline period and 29,051 person-years in the grant period (data not shown). This corresponds to the 10.3% increase for this group shown in Table 2-2.

It is possible for the percent distribution in a given sub-category to decrease from the baseline to the grant period even though enrollment in that sub-category grew over time in absolute numbers. This could occur if there is proportionately greater growth in other

subcategories. Similarly, we could observe an increase in the percent distribution despite a decrease in enrollment if other groups experienced a relatively greater decrease in enrollment.

Statewide enrollment trends in the MSP for the baseline and grant periods are presented in Table 2-2 and graphed in Figure 2-1. There was a 4.7% increase in total person-years of enrollment by the end of the grant period. The number of unique individuals enrolled in dual eligible programs increased by 7.4% from the baseline to the grant period. Programs targeted by the grant outreach efforts all experienced an increase in enrollment: 23.8% for QMB, 42.6% for SLMB and 187% for QI. In contrast, SSI/LTC/HCBS and Medically Needy programs experienced a slight decline. As seen in Figure 2-1, a sharp increase in enrollment during the grant period can be seen beginning in April 2001 and continuing through July 2001. This corresponds directly with the timing of two of the grant initiatives: the direct mailing with AARP and the direct mailing to ConnPACE participants.

Table 2-2 presents the MSP enrollment trends by various demographic characteristics such as age, race and area of residence. Except for the oldest-old, all age groups demonstrate an increase in enrollment. Those aged 85 and over experience a drop in enrollment of about 9%. While all racial groups experience an increase in enrollment, it is higher for Hispanics, Asians and Native Americans. Although increases for Asians and Native Americans are relatively large, these translate into small increases in the number of enrollees (820 and 150 respectively) because these groups constitute a small percentage of the overall population. No difference in enrollment trends can be seen between males and females, and enrollment increases are very similar in urban and rural areas. Figure B-2 in Appendix B charts the enrollment trends by program type through the baseline and grant periods. The outreach effort to sign up dual eligibles involved 5 different initiatives; four of these initiatives (the two direct mail campaigns, professional training and work with FQHCs) encompassed the whole State. Outreach to places of worship was only implemented in the Hartford area (North Central region). To isolate the effect of the outreach to churches initiative, Table 2-3 examines the differences in enrollment changes between the North Central region (demonstration area) and a similar urban area (West Haven) where this initiative did not take place (control area). Enrollment changes by region for all regions of the State are shown in Table B-1, Appendix B. The predominantly negative numbers in the column showing the difference in the change in enrollment over time in the demonstration area compared to control indicate that enrollment growth was slower in the demonstration area overall and for most sub-populations of interest. The Medically Needy program, which was the only eligibility group that experienced a greater enrollment increase in the demonstration area than in the control area, was not a program targeted by the grant effort. Thus, the analysis indicates that the outreach to places of worship initiative was not effective, which is consistent with the site visit finding.

Table 2-2

Statewide Changes in Dual Eligible Enrollment and Beneficiary Characteristics

	CONNECTICUT		
	Baseline Period	**Grant Period**	**% Change[1]**
# of Person-Years	69,680	72,944	4.7
# of Unique Enrollees	80,361	86,303	7.4
Age	%[2]	%[2]	
<65	37.8	39.8	10.3
65-74	20.2	20.7	7.3
75-84	22.6	22.6	4.6
85+	19.4	16.9	-8.8
Gender			
Male	35.7	35.6	4.4
Female	64.3	64.4	4.8
Race			
White	75.1	74.9	4.5
Black	12.5	12.5	4.1
Hispanic	11.1	11.3	6.5
Asian/Pacific Islander	1.1	1.1	7.9
Native American	0.2	0.2	8.2
Area of Residence			
Urban	98.2	98.1	4.6
Rural	1.9	1.9	5.6
Program Eligibility			
SSI/ LTC/ HCBS[3]	80.7	76.5	-0.7
SOURCE: RIT analysis of Connecticut Medicaid	6.1	7.2	23.7
SLMB	2.5	3.4	42.5
Medically Needy	9.2	8.8	-0.1
QI	1.2	3.3	187.4
Other	0.4	0.9	123.5

NOTES:

[1] Percent change in person-years of enrollment from baseline to grant period.

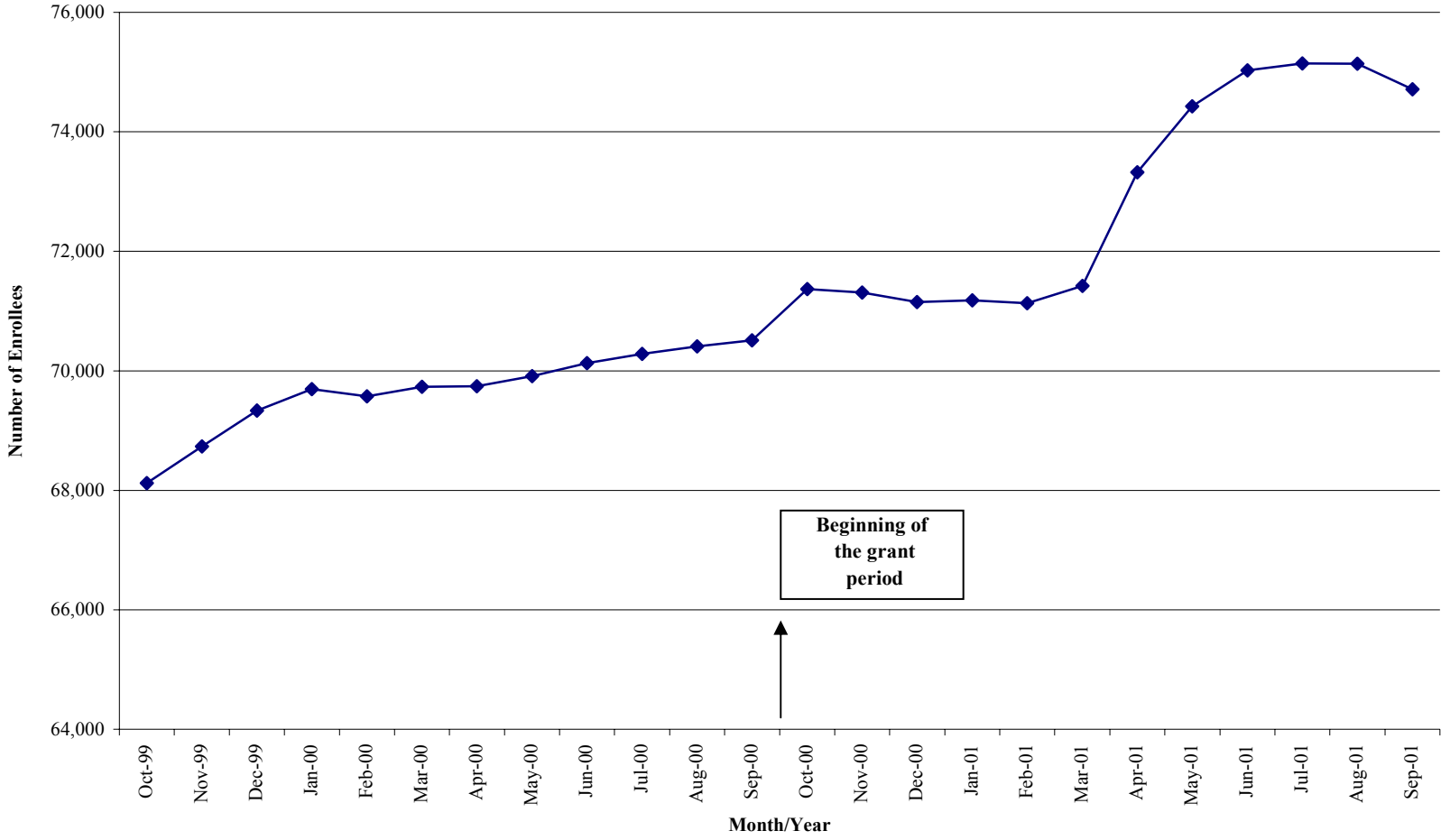
[2] Percent distribution with category. Numbers sum to 100 percent within category in each year.

[3] SSI- Supplemental Security Income; LTC-Long Term Care (institutionalized); HCBS- Home and Community Based Services.

SOURCE: RIT analysis of Connecticut Medicaid Eligibility Data, October 1999-December 2001.

Figure 2-1

Connecticut: Number of Enrollees by Month
(October 1999-September 2001)



Cost Data

The overall cost for the outreach grant was $261,202, which included $176,609 of Federal Funds, $34,553 in State matching funds and $50,040 incurred by AARP. The estimate for the breakdown of total costs by initiative is as follows: 20% for the AARP initiative, 30% for the ConnPACE mailing, 30% for the professional training, 10% for the FQHCs, and 10% for the NCAAA church initiative.

Table 2-4 presents data on the cost effectiveness of the Connecticut outreach enrollment grant initiative. Ideally, the cost effectiveness would be calculated using the number of new enrollees directly attributable to each grant initiative. However, data were not available on the number of new enrollees associated with most of the individual initiatives. Therefore, we calculated cost-effectiveness in several ways. We calculated the cost-effectiveness based on the overall program costs and the increase in person years of enrollment from the baseline to the grant period calculated from Medicaid eligibility data. For the AARP and ConnPACE initiatives, we were able to calculate cost per application received; however we do not have information on the number of applicants eventually enrolled in MSP for either of these initiatives. For the FQHC initiative, we use tracking data to calculate the cost per application received and the cost per enrollee.

As documented by the eligibility data, there was an increase of 3,264 person-years from the baseline to the grant periods. Assuming the all of these increases can be attributed to the grant initiatives, the cost of outreach per person-year of enrollment was $80. This undoubtedly overstates the cost-effectiveness of the overall grant because it is unlikely that all enrollment growth is a result of the grant initiatives. For outreach through FQHCs, about $312 was spent per application received and approximately $453 per enrollee. The AARP mailing cost was about $183 per application received. The mailing to ConnPACE recipients, which yielded many more responses, was by far the most cost-effective at about $17 per application received.

2.4 Conclusions

In implementing this grant, Connecticut had the following goals: to test five innovative and replicable outreach approaches to increase enrollment in dual eligible programs by establishing partnerships with various organizations. The major goal of the grant was achieved by increasing the statewide enrollment in the MSP by 4.7%. However, not all the approaches were equally effective. The direct mail campaign to ConnPACE recipients was the most successful in yielding new applications. Training to professionals provided the necessary knowledge base for advocates to carry on outreach activities. Utilizing Medicaid outreach workers at FQHCs widened access to a new pool of potential applicants. However, the direct mail to AARP members and outreach to places of worship initiatives were not effective.

Table 2-3

Outreach to Places of Worship in Hartford Area: Changes in Dual Eligible Enrollment and Beneficiary Characteristics, Demonstration and Control Areas

	CONNECTICUT						
	Baseline Period		**Grant Period**		**% Change[1]**		**Difference In % Change**
	Demonstration Area	Control Area	Demonstration Area	Control Area	Demonstration Area	Control Area	
# of Person-Years	259,906	201,017	271,032	211,231	4.3	5.1	-0.8
	%[2]	%[2]	%[2]	%[2]			
Age							
<65	38.1	36.6	40.2	38.6	10.1	10.9	-0.8
65-74	20.9	19.3	21.3	19.8	6.3	8.0	-1.7
75-84	22.5	23.5	22.3	23.6	3.1	5.8	-2.6
85+	18.5	20.7	16.2	18.0	-8.6	-8.7	0.1
Gender							
Male	36.6	34.8	36.5	34.7	4.0	4.7	-0.6
Female	63.4	65.2	63.5	65.3	4.4	5.3	-0.9
Race							
White	70.5	76.9	70.4	77.0	4.1	5.2	-1.2
African American	13.1	14.4	13.1	14.2	3.9	3.3	0.6
Hispanic	15.0	7.7	15.2	7.7	5.3	5.9	-0.6
Asian/Pacific Islander	1.2	0.8	1.3	0.9	8.7	12.9	-4.2
Native American	0.2	0.2	0.2	0.2	4.8	7.1	-2.3
Area of Residence							
Urban	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Rural	N/A	N/A	N/A	N/A	N/A	N/A	
Program Eligibility							
SSI/ LTC/ HCBS[3]	81.1	80.5	77.1	76.0	-0.8	-0.7	-0.1
QMB	6.1	5.9	7.0	7.1	18.5	27.8	-9.3
SOURCE: RIT analysis of Connec	2.1	2.3	3.0	3.3	45.9	50.0	-4.1
Medically Needy	9.0	9.8	9.0	9.2	4.2	-2.0	6.2
QI	1.3	1.1	3.2	3.4	156.9	224.2	-67.3
Other	0.4	0.4	0.8	1.0	121.1	131.3	-10.3

NOTES:

[1]Percent change in person-year of enrollment from baseline to grant period.

[2]Percent distribution within category. Numbers sum to 100 percent within category in each year.

[3]SSI- Supplemental Security Income; LTC-Long Term Care (institutionalized); HCBS- Home and Community Based Services.

SOURCE: RIT analysis of Connecticut Medicaid Eligibility Data, October 1999-December 2001.

Table 2-4

Connecticut
Program Costs and Cost-Effectiveness

	Program Costs				Increase in Enrollment		Cost-Effectiveness	
					Tracking	Eligibility	Tracking	Eligibility
	Federal[1]	State	Other[2]	Total	Data	Data[3]	Data	Data
	$	$	$	$			$	$
Total	176,609	34,553	50,040	261,202	-	3,264	-	80
AARP Mailing	21,456	1,181	50,040	72,677	396[4]	-	184	-
CONNPACE Mailing	58,464	28,372	-	86,836	5,238[4]	-	17	-
Outreach through FQHCs	65,234	-	-	65,234	209[5]	-	312	-
					144[6]	-	453	-
Professional training	11,968	5,000	-	16,968	-	-	-	-
Outreach to Churches	19,488	34,553	-	19,488	-	-	-	-

NOTES:
[1] Includes allocations of administrative and contractual costs
[2] Expenses incurred by AARP.
[3] Increase in person-years of enrollment from baseline to grant period.
[4] Eligibility data are reported in person years.
[5]Total number of applications received (including pending cases) by 12/31/01- no enrollment data available
[6] Number of applications received from FQHC Medicaid outreach workers after professional training resulting in enrollment by 12/31/01

SOURCE: RIT analysis of Connecticut Medicaid Eligibility Data, October 1999-September 2001.

The grant allowed partners to forge long-lasting and valuable relationships between DSS and other parties that will be an effective mechanism in all future outreach work for various State and Federal programs. The new relationship with the Connecticut Primary Care Association was considered especially important. Additionally, by improving existing relationships and forging new ties among stakeholders committed to serving the low-income elderly population, this grant established a strong network of State and advocacy organizations working together on recruiting for the MSP.

Overall improved knowledge and participation in the MSP was achieved by providing support, leadership and day-to-day advice from the central Connecticut DSS office to all grant partners. Using AAAs and AARP as facilitators in the outreach efforts diminished mistrust and stigma associated with government programs. Training providers and aging service staff in the MSP ensured continuing effective outreach among the potentially eligible population. Furthermore, this grant allowed training of various groups outside the traditional aging network, for example, providers working in FQHCs and those involved with younger disabled Medicare beneficiaries.

NCAAA felt establishing relationships with churches was a valuable connection, but one that needed to be fostered over a longer time frame. This effort served as an introduction of the AAA concept to religious communities but was, in the short-run, not successful in recruiting elders into the MSP. NCAAA staff concluded that repeated mailings would be beneficial for

further publicizing the programs and would make it possible to invite interested church staff to their volunteer training sessions.

The NCAAA initiative encountered some challenges. Identifying churches in the area proved to be a difficult and time consuming task. Additionally, the NCAAA had difficulty in identifying community outreach persons within each church as community outreach staff does not work standard hours and was difficult to reach. Compiling a mailing list for contacts was a lengthy process requiring many repeated calls. While the local Yellow Pages was an original source of information about religious institutions in the area, the addresses often proved incorrect. NCAAA felt the form letter explaining the MSP did not resonate with church staff since issues pertaining to public assistance were outside their usual domain. They also thought the MSP were too specific for churches to address, and an initial general introduction to AAA services might have been more effective. CHOICES staff also suggested that in the future they may need to narrow the focus and contact smaller groups, such as parish nurses or community leaders, instead of spending time and efforts to reach all religious institutions in the area.

In general, many participants reported that the time period for the grant was inadequate to implement all the activities: not enough lead-time was allowed to develop the outreach, and not enough time was devoted to effectively measure the outcomes. DSS staff believed that they substantially underestimated the time and effort needed to track, monitor and manage the operation when multiple partners are involved. Although the outreach effort to traditional populations of low-income Medicare beneficiaries participating in the aging network was successful, other groups such as geographically isolated and homebound elders and unassimilated ethnic /immigrant communities proved to be very difficult to reach. Outreach efforts to such communities requires more time and financial resources than this grant allowed, as well as language and cultural capabilities not easily obtainable.

AAAs encountered several challenges with the direct mailings. First, the AARP mailing was delayed waiting for DSS approval of the wording of the letter. This delay was detrimental as mailing lists became outdated. While the zip codes used in the AARP mailing were supposed to identify areas with low-income residents (200% of the federal poverty guideline), this screening was not successful. Affluent recipients were offended by receiving these mailings targeting low-income individuals. The ConnPACE mailing also followed the AARP mailing too closely, flooding residents with letters about the MSP. Additionally, the first wave of AARP mailing in one area (Western Connecticut) contained incorrect information and had to be repeated later with a second letter. Since one HMO in the area was also mailing out similar letters publicizing the same programs, some beneficiaries reported getting 3-4 letters advertising the MSP in a short time span.

The mailing to ConnPACE recipients proved successful and there was a strong response from ConnPACE beneficiaries. DSS staff attributed the success to the fact that the CONNPACE mailing list enabled them to effectively target a low-income elderly population that was likely eligible for MSP. In addition, the ConnPACE population may be more accepting of means-tested programs. CHOICES counselors reported receiving thousands of phone calls as a result of the direct mailing to ConnPACE enrollees. However, the initiative also created anxiety because

many people did not understand what the mailing was about. Some current enrollees thought they were being disenrolled from MSP. Thus, some applications from this initiative came from current program enrollees, creating additional burden on intake staff already overwhelmed with the large number of applications.

The FQHC initiative received far fewer applications than anticipated for several reasons. Once the intensive outreach effort was underway, it became clear that many of the FQHCs' active or potential clients were eligible for or were already receiving full Medicaid or were illegal immigrants ineligible for any program. Outreach workers were also challenged to shift priorities towards elder issues after focusing on families, children and pregnant women for many years. Outreach workers had trouble absorbing the information about Medicare and the MSP in a one-day training format. Additional efforts had to be made to overcome cultural barriers. Outreach workers found that ethnic elders, who represent a large proportion of the elderly population served by FQHCs, are reluctant to share sensitive information about their income and needs. Furthermore, health centers do not have enough staff and resources to do a substantial number of one-on-one home visits, which they judged to be the most effective outreach for this type of low-income population.

Some issues were not addressed through this grant. Limitations on Medicaid reimbursement for Medicare Part B co-insurance and estate recovery remain the most serious barriers to program participation in Connecticut. Although Connecticut has adopted shortened application and recertification forms, another effort is needed to simplify the confirmation of enrollment letter. It is reported to be confusing and complicated even for CHOICES counselors.

While not specifically excluded, physicians and staff at the medical offices were not integrated in the educational effort that was part of this grant. Since it was determined that they also lack understanding of the MSP, it would be beneficial to train them.

The grant also could not address the multiple names used by these programs that proved to be so confusing for beneficiaries and providers alike. Many among advocates, providers, beneficiaries, and DSS regional office staff were baffled by acronyms and complicated program names.

Materials and bilingual staff were only available for the Spanish speaking population, which is relatively well-connected to various civic organizations and institutions. For other groups (Polish, Chinese, Colombian, Cambodian, Laotian, Vietnamese and Bosnian) the situation was different: communities were closed to outsiders and difficult to penetrate. These groups were not connected traditionally to organizations such as senior centers or meal sites, and they did not attend health fairs. As bilingual staff to work with these groups was difficult to recruit, AAAs could not undertake many of the outreach activities that were initially planned.

Connecticut had an ambitious grant initiative that consisted of five different activities. The outreach efforts in total proved effective, as there was a substantial increase in MSP enrollment. Total enrollment in all the programs, measured in person years, increased by 4.7%, with a 23.7% increase for QMB, 42.5% increase for SLMB and 187.4% increase for QI

programs. In contrast, there was no growth in enrollment for the SSI/LTC/HCBS and Medically Needy programs, which were outside the focus of the grant.

Additionally, there was enrollment growth among vulnerable groups specifically targeted by the outreach efforts: enrollment of Hispanic beneficiaries increased 6.5% while enrollment of African-Americans increased 4.1%. While the grant also attempted to increase enrollment of the homebound and widowed, as well as elders living alone, available data did not allow us to assess how successful the initiatives were at reaching these groups. The 8.8% decline in enrollment for elders aged 85 and older suggests that this goal may not have been achieved.

Valuable lessons about the design of future outreach efforts can gathered from the varying results of the different initiatives undertaken in Connecticut. For example, the differing experiences from the ConnPACE and AARP mailings show that, while mailings can be effective, they need to be carefully targeted to potentially eligible populations. This is challenging in the absence of a mailing list that permits effective identification of low-income groups, such as one from a program with similar eligibility requirements. As seen in the FQHC initiative, while home visits maybe effective, they are expensive. Professional training produces greater familiarity with the programs for the trained staff and promotes an exchange of ideas, but does not lead to immediate enrollment increases due to various barriers that still exist and challenges to conducting outreach in the field. Training should also be well targeted. Aging advocates volunteering at AAAs are familiar with aging issues and need specific training on MSP, but Medicaid outreach workers at FQHCs, who are not used to working with an elderly cohort, would benefit from a broad introduction to aging and health issues before getting a detailed training on MSP.

Outreach to churches is an innovative approach that requires time and effort and should be considered as a long-term investment in building community ties. Without a strong and established working relationship between AAAs and religious institutions, it is premature to expect this type of outreach to result in application increases. In conducting outreach to this population, the trade-offs must be considered. Overall, this initiative required more effort than was originally anticipated. While DSS had some experience in contacting churches, no organized large-scale effort such as this grant initiative was ever tried previously.

CHAPTER 3
MARYLAND

3.1 Program Overview and Background

In 1997 Medicare HMOs began withdrawing from the rural areas of Maryland. Over a period of three years, all HMOs withdrew from the rural areas and left approximately 150,000 seniors without a supplemental policy and without prescription drug coverage. (The HMOs had a $0 premium product that included prescription drug coverage.) The State, seeing the MSP as a way of responding to seniors in need, became proactive in its outreach activities at this time. In 1999, the State sought and received a grant from the Centers for Medicare & Medicaid Services (CMS) for outreach for the MSP. MAC, Inc., the AAA for the four counties on Maryland's Lower Eastern Shore, was selected for a pilot project, as this area was particularly affected by the HMO withdrawals.

Then in September 2001 Maryland was awarded a second grant through CMS's initiative "Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles." With this second grant Maryland directed four AAAs in four rural regions of the State to hire dedicated outreach coordinators to promote the MSP. It was the State's goal to increase the number of applications by 5% in the grant regions. In addition, the State sought to create long-term partnerships to continue promoting the MSP and access to care for this population. The State also hoped to pilot a mail-in application during the grant period.

At the State level, Maryland partnered with numerous agencies and groups for this second grant. The initiative was a collaborative effort between the Department of Health and Mental Hygiene, the Department of Aging and the Department of Human Resources. The State departments had the following roles:

- the Department of Health and Mental Hygiene was the lead agency and was the liaison between the partners and the State. The Department of Health and Mental Hygiene was also responsible for training the local Departments of Social Services, State health insurance counselors, among others, about the MSP;
- the Department of Aging chose the four AAAs to participate in the grant;
- the Department of Human Resources and the local Departments of Social Services educated their staff about the grant and the shorter application form. The staff also coordinated receipt of the applications from the surrogates and prcessed them to determine MSP eligibility.

The Department of Health and Mental Hygiene received letters of support for the grant from its partners at the State level as well as the AARP, the Maryland Rural Health Association and the AAAs. In addition, the Department of Health and Mental Hygiene and the Department of Aging signed a Memorandum of Agreement to fund the AAAs for the grant. The four grantees were:

MAC, Inc. (Lower Eastern Shore), Upper Shore Aging, Inc. (Upper Eastern Shore), Community Action Committee, Inc. (Western Maryland), and St. Mary's County Office on Aging (Southern Maryland). (A map of the State is included in Appendix C, Figure C-1.) The AAAs partnered with various local agencies and organizations to assist them in conducting outreach and promoting the MSP to all elderly and disabled potentially eligible for the programs. Partners on the local level included Department of Social Services' offices, health departments, Social Security offices, senior centers and senior housing, as well as the media.

Maryland also has an Interagency Committee on Aging that consists of cabinet-level members from most State departments focusing on aging issues and includes a subcommittee that focuses on QMB and SLMB specifically. The Interagency Committee on Aging identified QMB/SLMB enrollment as a high priority area, which was a critical development as it assured support for the grant initiative from State department heads.

The State used lessons learned from the pilot and applied them to the grant's demonstration areas. During the pilot program, the State and MAC learned that there were two major barriers to enrolling in the MSP: the length of the application and the requirement to apply at the local Department of Social Services offices. In response, a shorter application was developed and a surrogate system instituted for use statewide where trained volunteers assisted beneficiaries in completing the MSP applications and delivering them to local Department of Social Services offices.

Prior to the pilot program on the Lower Eastern Shore, the application for applying to the MSP was 28 pages long. It was a generic application for all types of assistance programs, e.g., Medicaid and Food Stamps. Therefore, not all of it was applicable to a beneficiary applying for the MSP, and it had to be read carefully to determine which sections were relevant to them. As a result of the pilot on the Lower Eastern Shore, a short, four-page application pertaining only to the MSP was implemented statewide. A copy of the shortened application is contained in Appendix C.

Prior to the pilot, all applications had to be completed at the local Department of Social Services offices. This was also a barrier to enrollment because of the welfare stigma attached to State programs, and the lack of transportation in some areas which created difficulty for seniors in getting to the offices with the required documentation. During the pilot a "surrogate" system was tested and later implemented statewide. The surrogate system allowed trained staff from AAAs or volunteers to complete and submit MSP applications on behalf of beneficiaries at the AAAs or in the homes of the homebound. This alleviated the need for beneficiaries to visit local social services offices. The surrogates were trained by the Department of Health and Mental Hygiene to verify as much information as possible, and sometimes worked in partnership with the Department of Social Services caseworkers to do so.

Other barriers were identified during the pilot as well. There was a lack of knowledge about the program among beneficiaries, family members, providers and organizations that communicated with seniors. Advocates also believed that there was a general disinterest in the program, as much of the eligible population grew up during the Depression and had learned how

to do without. Even now, many forego necessities, such as prescription drugs, instead of asking for assistance. Seniors are particularly reluctant to ask for assistance from the State. Many seniors have transportation problems, especially in areas with little, if any, public transportation. Seniors also need assistance with the application process, from completing the application to gathering documents. In some parts of the State, there are high rates of illiteracy among the elderly, which make it difficult to educate people about the program and assist them with the application.

For seniors who are interested in the MSP, one of the major barriers to the programs is estate recovery. Many fear that they will lose their home and assets although the application includes the following language: "I also understand that the State may recover from the estate of any person over 55 years old an amount not to exceed the amount of benefits paid out on behalf of that person." Advocates report that seniors find this language difficult to understand and confusing. Many seniors would rather forego the benefits of the program in order to leave their children something.

The surrogate system was also designed to assist with the complicated redetermination process. Redetermination for the programs is required annually, and notification is sent to the beneficiary. Advocates informed us that the notification of recertification is confusing as it states first that the person has been denied for medical assistance. Only on a later page is the applicant notified that he has been approved for QMB and that he will be contacted in order to review eligibility. In some counties staff at AAAs now assist beneficiaries with this process. Since our site visit, Maryland has established a Notice Committee to review all notices for medical assistance.

If a beneficiary does not reapply for the program, he is automatically terminated. However, some beneficiaries do not read their mail, do not understand the letters they receive and ultimately ignore the redetermination process. Maryland addressed this in the pilot and later on a statewide basis by allowing surrogates to be identified on the application as representatives of the beneficiary. Beneficiaries can elect surrogates to receive the following information and take the following actions:

- receive letters about eligibility and discuss eligibility with the Department of Social Services and the Department of Health and Mental Hygiene;
- receive and complete initial and recertification applications; and,
- receive beneficiary identification cards.

This enables surrogates to keep track of beneficiaries' status and assist them with any problems in the application process or recertification. The new application for recertification is identical to the shortened initial application with the exception of the color of the paper it is printed on.

Since 1995 the QMB/SLMB Buy-In Unit within the Department of Health and Mental Hygiene has received Leads Data from the Social Security Administration that identifies new Medicare beneficiaries. Social Security screens new beneficiaries for eligibility for these buy-in programs (based on the amount of the Social Security benefit). The State then mails eligible

beneficiaries letters describing the QMB program only (no other program is described in this letter). The letter refers them to a local Department of Social Services office or AAA for additional information and provides telephone numbers to call.

3.2 Program Implementation and Operation

Successful aspects of the Lower Eastern Shore pilot were expanded statewide: the shortened application and the use of surrogates. The grant initiative focused on three additional rural areas of the State – Western Maryland, Southern Maryland, and the Upper Eastern Shore. The Lower Eastern Shore, which had been in the pilot, was retained as part of the grant program. Each area used grant funds to hire an outreach coordinator for the AAA to specifically promote the MSP. Each of the four selected regions was also given a marketing budget for materials, paid media and other outreach costs. Two of the outreach coordinators were hired at the beginning of 2001, while the Lower Eastern Shore's outreach coordinator was kept on from the pilot program. The outreach coordinator in Southern Maryland was hired during the spring of 2001, roughly halfway into the grant period. Because of the late hiring in Southern Maryland, the AAA also hired a part-time outreach specialist.

The outreach coordinators at the AAAs conducted a variety of outreach to promote the MSP. Many conducted the same kinds of outreach, although some types of outreach varied in their effectiveness depending on the region. Types of outreach included:

- tables at malls and displays at libraries about the MSP;
- talks at senior centers, senior housing, civic groups, AARP meetings, health fairs and senior fairs;
- PSAs on radio and television, as well as sponsoring news on the radio;
- PSA prior to movie screenings in theaters;[1]
- guest appearances on cable television and radio talk shows;
- brochures at doctors' offices, local Social Security offices and pharmacies;
- advertisements in newspapers, on billboards and on the sides of buses; and
- presentations at churches.

The outreach specialists designed various types of brochures, examples of which are included in Appendix C. Each tried to come up with catchy slogans and descriptions of the programs. One brochure asked, "How would you like to save on those out of pocket medical expenses?" while another advertised "Affordable Medicare!" Each AAA included its address and telephone number as contact information. One outreach specialist always wore a bright yellow pin that said, "Ask Me About Affordable Medicare."

[1] This method was done in one region prior to the release of *Pearl Harbor* because of the number of Medicare beneficiaries (veterans) likely to be in attendance in the audience.

Outreach specialists were successful in gaining the support of local partners such as the media. A local radio station in one area donated considerable discounts on radio ads, while a billboard company in another area reduced its normal rate by 80 percent to advertise the MSP.

Only some of the outreach specialists assisted beneficiaries with completing applications. In one region it was decided that the outreach specialist should just inform beneficiaries about the program and not become involved with completing applications. The AAA was concerned that seniors might be opposed to having the same person educate them about the program and then learn about their finances and situations.

At the time of the site visit, the State was planning to pre-test a mail-in application to further reduce the stigma and transportation concerns. However, advocates were concerned about this because they feared beneficiaries would not receive the help they needed in completing the applications, although the application did provide contact information for the AAAs. According to the State's Evaluation Report (Maryland Department of Health and Mental Hygiene, April 15, 2002), the mail-in application was pretested after the grant period, from January 22, 2002 through February 22, 2002. The State has not decided whether it will implement a mail-in application.

3.3 Program Enrollment and Cost Impacts

Tracking Data

Maryland did not directly track applications submitted or beneficiaries enrolled as a result of the activities funded under the grant, as the State has found it difficult from experience to attribute applications to specific outreach activities when these often cross regions (e.g., information from the media, posters on the side of buses). The tracking information the State reported in its final report was the number of applications and redeterminations received for the pre-grant year as well as for the grant period. Based on the number of applications and redeterminations cited in Maryland's final report, we calculate that, with the exception of Southern Maryland, each region experienced a decrease in the number of applications and redeterminations received overall (Table 3-1). While Western Maryland's decrease was small (-1.1%), the number of applications plus redeterminations received in the Lower Eastern Shore and the Upper Eastern Shore decreased by 4.1% and 6.2%, respectively. Because the grant period was 15 months (October 2000-December 2001) and the baseline period was 12 months long (October 1999 - September 2000), we deflated grant period statistics by (12/15) to make them comparable to the baseline period when we calculated the percent change. Although the State notes the different timeframes, it did not adjust for them. Instead of showing a 22% increase in applications and redeterminations as Maryland did in its final report to CMS, we actually report an overall decrease of 2.1%.

The decrease in number of applications and redeterminations received between the pre-grant and grant periods may be due to several reasons. First, HMOs began to withdraw in 1998 causing beneficiaries to search for other forms of coverage and assistance. The State may have experienced an increase in applications during this time period. Second the pilot occurred in

Table 3-1

Maryland: Number of Applications Received in Pre-grant and Grant Periods

	Applications in Pre-Grant Period	Redeterminations in Pre-Grant Period	Applications in Grant Period	Redeterminations in Grant Period	Percent Change Between Pre-Grant and Grant Periods in Applications and Redeterminations Received
Lower Eastern Shore	8,348	11,720	9,695	14,360	-4.1
Upper Eastern Shore	8,804	11,699	10,101	13,928	-6.2
Southern Maryland	6,569	8,792	8,302	11,625	3.8
Western Maryland	14,071	20,363	17,448	25,140	-1.1
Overall	37,792	52,574	45,546	65,053	-2.1

NOTES:
To calculate percent change, the grant period data are annualized in the calculation to allow for comparison with the baseline period. Due to the annualization, the percent change may reflect a decrease although the number of applications and redeterminations received is actually higher in the grant year. It should further be noted that these applications and redeterminations are the total number received, not just those directly related to grant activities.

SOURCE:
Maryland Department of Health and Mental Hygiene, "Building Partnerships in Maryland to Reach and Enroll Dual Eligibles, Evaluation Report." April 15, 2002.

1999. As a result of the pilot, surrogates and shortened application were implemented statewide. Because of these two events, the number of applications in the pre-grant period may have been higher than it would have been absent these events. When the grant began, seniors who were interested in enrolling may have already applied, while seniors who were not enrolled may have already decided they were not interested. Thus, the pool of available eligible nonenrollees in the rural areas could have dwindled. However, because the number of redetermination applications are included in our calculations, we do not expect to see the number of applications (both new and redetermination) to decrease. This may indicate a problem with Maryland's redetermination process (which they are looking into according to their final report).

Maryland also set numerical goals for the types of outreach conducted consisting of:

- 120 meetings per region with community groups (e.g., service clubs, sororities/fraternities, senior groups, faith communities, and health systems/physician groups) in each region that agreed to join outreach efforts;
- training 260 providers during the grant period (Department of Social Services staff, local Social Security Administration staff, SHIP counselors, Information and Assistance staff, long-term care ombudsmen) about the Medicare buy-in programs;
- having surrogates assist 300 beneficiaries during the grant period in completing the MSP applications; and
- screening applicants over the phone or conducting home visits to 400 potential eligibles during the grant period.

According to Table 3-2, Maryland exceeded its goals in three of the four activities. There were 539 providers who were trained, 569 applications that were completed with the assistance of surrogates and 1,379 beneficiaries who were screened over the phone or visited at their home. However, although there were nearly 300 meetings with community organizations, no region independently reached the goal of 120.

Medicaid Eligibility Data

RTI received data from Maryland on dual eligibles for the baseline period (October 1, 1999 through September 30, 2000) and the grant period (October 1, 2000 through December 31, 2001). The control area consisted of all counties in the State that were not included in the grant: Baltimore City, Anne Arundel, Baltimore County, Carroll, Harford, Howard, Montgomery and Prince George's. These counties are decidedly more urban than the demonstration counties and, therefore, are an imperfect control. The demonstration regions consisted of counties in Southern and Western Maryland and the Upper and the Lower Eastern Shores.

We received program eligibility data for the following categories: SSI, QMB, SLMB, Medically Needy and QI-1s. Because QI-2s receive an annual benefit, they are not included in the Medicaid eligibility files, but rather in a separate State file. In addition, there were a number of enrollees with multiple coverage codes. For persons with both SSI and QMB coverage codes,

Table 3-2

Maryland: Comparison of Outreach Conducted to Goals Outlined in Proposal, by Region

	Meetings with Community Groups	Providers Completing Buy-In Training	Applications Completed by SHIP/I&A	Telephone Screenings Completed and Home Visits
Goal	**120**	**260**	**300**	**400**
Lower Eastern Shore	97	127	309	531
Upper Eastern Shore	56	47	71	92
Southern Maryland	34	197	35	206
Western Maryland	110	168	154	550
Overall	297	539	569	1,379

SOURCE:
Maryland Department of Health and Mental Hygiene, "Building Partnerships in Maryland to Reach and Enroll Dual Eligibles, Evaluation Report." April 15, 2002.

we included them in the SSI category; for persons with both Medically Needy and SLMB coverage codes, we included them in the Medically Needy category.

The table presenting statewide enrollment changes (Table 3-3) is organized as follows. The first two columns show the percent distribution within each category (e.g., gender, age, and race) for the baseline and grant periods, respectively. For example, in the baseline period 35.7% of the dual eligibles were under 65 years of age, whereas 38.9% of dual eligibles fell in this age group during the grant period. The third column shows the percent change in enrollment from the baseline to the grant period for dual eligibles overall and for subcategories of eligibles. For example, in the under 65 age group there were 24,922 person-years of enrollment during the baseline period and 27,086 person-years in the grant period (data not shown). This corresponds to the 8.7% increase for this group shown in Table 3-3.

The overall changes in person years and number of unique individuals appear contradictory. There was a very small decrease in enrollment of dual eligibles from the baseline to the grant period (a 0.2% decrease in person years of enrollment). On the other hand, there was a small increase (2%) in the number of unique beneficiaries enrolled. However, comparing the number of unique beneficiaries in the baseline and grant periods is misleading because of the difference in the time periods covered. Although we can adjust the number of person years to control for this difference (deflating the number of person years in the grant period by 12/15), this type of adjustment is not appropriate for the count of unique individuals.

There was a 2.9% increase for duals in the 65-74 age category. However, enrollment decreased from the baseline period to the grant period for those aged 75+ and particularly for those over 85. The change in enrollment was similar for women and for men. Duals in urban areas experienced virtually no change in enrollment, while beneficiaries in rural areas experienced a small decrease. From the baseline to grant periods, there were large increases in enrollment for Hispanics, Asian and Pacific Islanders and duals of unknown races (13.2%, 9.0% and 10.1%, respectively). The data indicate that all of the MSP experienced large percentage decreases from the baseline to grant periods with the exception of the SSI program, which experienced an increase of 6.3%. In general, we expect SSI enrollment to be less affected by the outreach grant than other dual eligible programs because the focus was on assistance with premiums and cost sharing. However, in assisting beneficiaries with applications and conducting outreach at various locations, beneficiaries may have either learned about the SSI program or applied for the MSP and been referred to SSI. Table C-1 in Appendix C presents the percent change in enrollment by demonstration region and control counties between the baseline and grant years. Each area in the demonstration experienced a small decrease overall while the control experience a small increase.

The data in Table 3-4 describe the change in enrollment between the baseline and grant periods for the demonstration and control areas. Overall, the number of person years decreased by 1.4% in the demonstration areas but increased by 0.2% in the control area. However, results from CMS' analysis of the Third Party Premium Billing File indicates that Maryland experienced a 5.9% increase in enrollment from September 2000 to September 2001 (CMS, 15 April 2002).

Table 3-3

Statewide Changes in Dual Eligible Enrollment and Beneficiary Characteristics

	Maryland		
	Baseline Period	**Grant Period**	**% Change[1]**
# of Person-Years	69,802	69,667	-0.2
# of Unique Enrollees	80,926	82,529	2.0
	%[2]	%[2]	
Age			
<65	35.7	38.9	8.7
65-74	26.0	26.8	2.9
75-84	24.0	22.8	-5.1
85+	14.3	11.5	-19.6
Gender			
Male	33.4	33.3	-0.5
Female	66.6	66.7	0.0
Race			
White	51.8	50.9	-1.9
Black	38.9	38.8	-0.4
Hispanic	1.7	1.9	13.2
Asian/Pacific Islander	4.7	5.2	9.0
Native American	0.2	0.2	0.7
Unknown	2.8	3.0	10.1
Area of Residence			
Urban	88.4	88.6	0.0
Rural	11.6	11.4	-1.5
Program Eligibility			
SSI	80.6	85.8	6.3
QMB	7.9	6.7	-15.9
SLMB	1.1	0.9	-21.1
Medically Needy	10.3	6.6	-36.2
QDWI	0.1	0.1	0.0
QI-1	0.0	0.0	0.0
QI-2	0.0	0.0	0.0

NOTES:

[1] Percent change in person-years of enrollment from baseline to grant period.

[2] Percent distribution within category. Numbers sum to 100 percent within category in each year.

SOURCE: HER analysis of Maryland Medicaid Eligibility Data, October 1999 - December 2001.

Table 3-4

Changes in Dual Eligible Enrollment and Beneficiary Characteristics, Demonstration and Control Areas

	MARYLAND						
	Baseline Period		Grant Period		% Change[1]		Difference in % Change
	Demonstration Area	Control Area	Demonstration Area	Control Area	Demonstration Area	Control Area	
# of Person-Years	17,944	51,858	17,687	51,980	-1.4%	0.2%	-1.7%
Age	%[2]	%[2]	%[2]	%[2]			
<65	35.2	35.9	39.2	38.8	9.8	8.3	1.5
65-74	25.5	26.2	25.6	27.2	-0.9	4.1	-5.0
75-84	24.5	23.8	23.1	22.7	-6.9	-4.5	-2.4
85+	14.8	14.1	12.0	11.3	-20.0	-19.5	-0.5
Gender							
Male	34.4	33.1	34.5	32.9	-1.1	-0.3	-0.8
Female	65.6	66.9	65.5	67.1	-1.6	0.5	-2.1
Race							
White	69.8	45.5	69.6	44.5	-1.7	-2.0	0.3
Black	26.4	43.2	26.4	43.0	-1.3	-0.2	-1.1
Hispanic	0.4	2.1	0.5	2.3	16.4	13.0	3.4
Asian/Pacific Islander	0.6	6.2	0.6	6.7	7.8	9.0	-1.2
Native American	0.1	0.2	0.1	0.2	20.0	-2.5	22.5
Unknown	2.7	2.8	2.7	3.1	-1.7	14.2	-15.9
Area of Residence							
Urban	55.0	100.0	55.0	100.0	-1.4	0.2	-1.6
Rural	45.0	0.0	45.0	0.0	-1.5	0.0	-1.5
Program Eligibility							
SSI	71.3	83.8	78.2	88.4	8.1	5.7	2.4
QMB	12.6	6.3	10.9	5.2	-14.9	-16.6	1.7
SLMB	1.8	0.9	1.4	0.7	-20.1	-21.9	1.8
Medically Needy	14.2	9.0	9.4	5.7	-34.9	-36.9	2.1
QI-1	0.2	0.1	0.2	0.0	-18.5	-22.2	3.8

NOTES:

[1] Percent change in person-years of enrollment from baseline to grant period.

[2] Percent distribution within category. Numbers sum to 100 percent within category in each year.

SOURCE: HER analysis of Maryland Medicaid Eligibility Data, October 1999 - December 2001.

The State could not identify the source of the discrepancy between these data and its Medicaid eligibility files.

In the demonstration area, only individuals under the age of 65 experienced an increase in enrollment (9.8%); all other age groups experienced declines ranging from 0.9% to 20%. While White people, Black people and individuals of unknown race/ethnicity experienced small decreases in enrollment, Native Americans, Hispanics and Asian Pacific Islanders all experienced enrollment increases in the demonstration areas. In addition, all eligibility categories experienced declines in enrollment, with the exception of SSI, which experienced an 8.1% increase in enrollment in the demonstration area. The trends followed similar patterns in the control area with a few exceptions. Most notably, as in the demonstration area, all eligibility categories other than SSI experienced declines in enrollment.

The "difference in change" column identifies the impact of the demonstration, using control site experience to net out changes in enrollment that would have been expected in the absence of the demonstration. Based on this analysis, there is no evidence that the grant initiative increased enrollment overall. Enrollment in the demonstration area declined by 1.7% relative to what would be expected based on experience in the control counties. However, there are certain subpopulations where the demonstration areas experienced growth relative to the controls, including the under 65 group, and the Native American, Hispanic and the SSI populations. Although enrollment of all eligibility categories other than SSI fell in both the demonstration and control areas, the decrease was smaller in the demonstration areas.

Figure 3-1 presents enrollment trends from October 1999 through December 2001 for the demonstration and control counties as well as the State overall. Statewide, enrollment increased throughout the baseline period, and, following a dip in October 2000, it increased slightly and then declined slightly toward the end of the grant period.[2] The trend in the control counties followed a similar pattern. However, the trend line for demonstration counties was comparatively flat throughout the baseline and grant periods. Figure C-2 in Appendix C displays enrollment trends by program during the pre-grant and grant year. Only the SSI program experienced an increase with the remaining programs exhibiting relatively flat, if not decreasing, trends.

Figure C-3 presents enrollment trends from October 1999 through December 2001 for each of the demonstration regions. Enrollment appears to increase in all regions during the pre-grant period. However, all regions experience a decrease between September and October 2000 although for some it is steeper (e.g., Western Maryland). Overall, the trends are generally flat during the grant year.

Cost Data

Table 3-5 displays the program costs of the initiatives by region. Each region received $41,820 from the federal government. The Lower Eastern Shore received extra funding to pilot

[2] RTI contacted the State and confirmed that the data extraction was performed the same way for both periods. The State believes that this decline in enrollment may have been due to beneficiaries failing to complete the redetermination process.

Figure 3-1

Maryland: Number of Enrollees by Month, Demonstration and Control Areas
(October 1999 - December 2001)

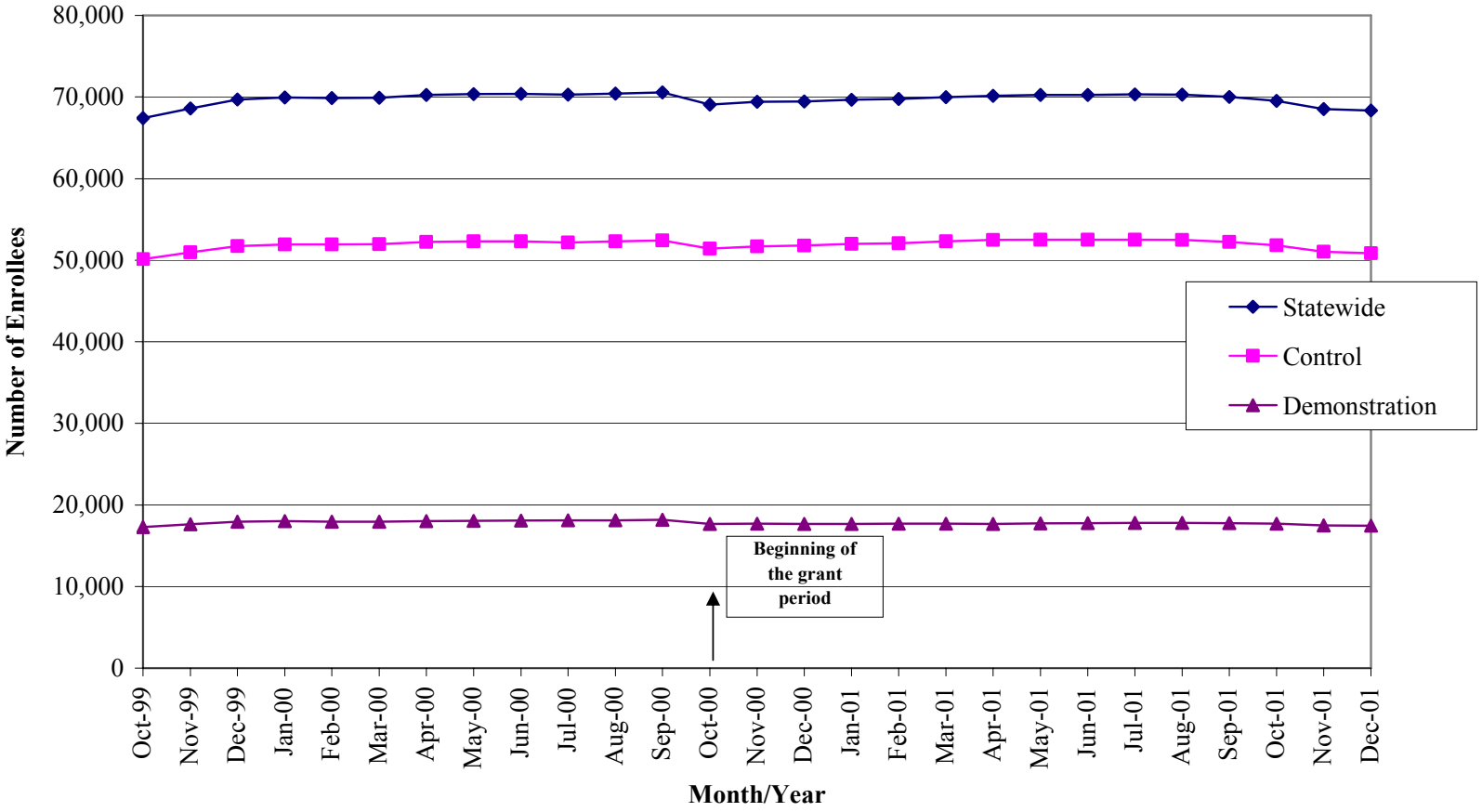


Table 3-5

Maryland
Program Costs

	Program Costs		
	Federal	State [1]	Total
Maryland	$	$	$
W.Maryland	41,820	12,402	54,222
Upper East	41,820	12,402	54,222
Lower East	46,350	12,402	58,752
S. Maryland	41,820	12,402	54,222
Total	171,810	49,606	221,416

NOTES:
[1]Maryland contributed in-kind salary amounts of $49,606 total. This amount was allocated equally across regions.

SOURCE: Maryland Department of Health and Mental Hygiene, "Building Partnerships in Maryland to Reach and Enroll Dual Eligibles, Evaluation Report." April 15, 2002.

test the mail-in application. The State then contributed in-kind salary amounts for a total of $49,606, which we allocated equally across the four regions. The total funding for the grant was $221,416. The Upper Eastern Shore, Southern and Western Maryland all received a total of $54,221.50 and the Lower Eastern Shore received $58,751.50. We did not calculate the cost-effectiveness of Maryland's grant program because, based on our comparison with control county enrollment, growth in the demonstration area was less than what would have been expected in the absence of the grant.

3.4 Conclusions

Despite our results indicating that there was a slight decrease in enrollment, all of the partners we interviewed believed that the grant program was successful. The program benefited from high-level political support at the State and MSP enrollment was identified as a priority by the Interagency Committee on Aging. Not only was the State working to increase enrollment through a variety of outreach and enrollment initiatives, it was also considering abolishing the estate recovery requirement for the programs.[3] The strong State support was particularly important given the State's large Medicaid program deficit.

[3] The State had conducted an analysis of the cost of waiving estate recovery and found it to be small.

Prior to the grant a shorter application and the surrogate system were implemented in the Lower Eastern Shore, and their implementation statewide coincided with the beginning of the grant period. Both the shorter application and surrogate system addressed advocates' concerns about transportation barriers and beneficiaries' need for assistance with completing the application. The welfare stigma was also addressed through the surrogate system because the beneficiaries no longer had to visit the Department of Social Services office to complete an application. The lessons that the State has learned in overcoming barriers to enrollment have been applied to other programs as well. For example, at the time of the site visit, the State was using the MSP application as a model for a streamlined home and community based care waiver program and other program applications.

AAAs have also learned lessons through this initiative. They believed that personal, one-on-one assistance to applicants is very important. Outreach specialists reported that often an applicant would not complete the MSP application initially, but would over time as a relationship developed with the surrogate. AAAs realized that one type of outreach was not sufficient, and what would work in one area, might not in another. For example, newspaper articles are effective for elders who read, but presentations might be more effective for those who could not.

AAAs increased the strength of their partnerships through this grant initiative. Outreach specialists provided information and brochures about the programs to local health departments, who perform in-home assessments, to energy assistance workers and to housing managers. They, in turn, provided information about the programs to potential beneficiaries. AAAs also developed local partnerships that had unanticipated results. AAAs received generous in-kind contributions that many had not foreseen, for example, discounts for advertisements or free advertisements. Local partnerships also reached audiences that the State would not think to target or would not have access to. For example, in one region, local fire departments were targeted because they sponsored Bingo games, which attract a fair number of beneficiaries.

There are, however, a number of remaining problems that were not addressed by the grant. The asset reporting requirements still pose a barrier for beneficiaries. Typical assets include life insurance policies with modest cash values that beneficiaries intend to use for funeral and burial expenses, as well as small plots of land that were once part of family farms. Maryland is currently considering changes to how burial funds and other assets are evaluated. As mentioned above, estate recovery also remains a barrier, although we recently learned that the States is in the process of eliminating this requirement.

In one region the language on the application related to voter registration was perceived as a barrier. The language asked applicants if they were registered to vote and if not, whether they wished to receive a registration form. This was reportedly perceived by applicants as a violation of privacy, although it was not perceived as a barrier in other regions.

Finally, despite the adoption of a shortened recertification application, the recertification notice itself remains confusing to enrollees. It first notifies the beneficiary that he is denied (or

ineligible for) medical assistance. Only on a later page is the beneficiary informed that he is eligible for MSP. It is helpful that copies now go to surrogates, but outreach coordinators identified as a future goal a streamlined, easy-to-understand letter. Subsequent to the grant period, the State has established a Notice Committee for this purpose.

During the site visit all informants expressed a strong belief that the demonstrations gave an important focus to MSP outreach that otherwise would not exist. While the outreach specialists hired through the grant and the AAAs appeared dedicated to the program, analysis of Medicaid eligibility data did not provide any evidence that the demonstration increased enrollment of dual eligibles. Enrollment in the demonstration site declined both in absolute numbers and relative to the control site. However, the actual decrease was small.

There might be several possible explanations for these results. First, the control was not similar in characteristics to the demonstration area. The control counties were mostly urban, while the demonstration were largely rural. Second, it was difficult to evaluate the impact of the grant due to the events that occurred during the pre-grant period (increased enrollment in the MSP due to HMO withdrawals, statewide implementation of a shortened application form and the surrogate system, and the Lower Eastern Shore pilot program). These factors may have led to a smaller pool of available eligible nonenrolles. In addition, because activities in the Lower Eastern Shore continued from the pre-grant to the grant periods, we may not expect much change in this region. Third, this population remains difficult to find and, despite concerted efforts, the impacts of outreach on enrollment may be minimal. Finally, seniors may know about the programs but still choose to not enroll.

CHAPTER 4
MINNESOTA

4.1 Program Overview and Background

For this grant Minnesota developed and tested various approaches to improve outreach to dual eligible older adults living in targeted rural areas and to increase enrollment in the MSP. The approaches adopted in Minnesota's grant included statewide efforts, as well as efforts targeting limited demonstration and pilot areas:

Statewide

- employ a social marketing firm for consulting on effective outreach methods for the elderly population; and
- design, implement, and evaluate a statewide television marketing campaign.

Demonstration areas only

- design, implement, and evaluate radio marketing campaign;
- distribute informational brochures and promotional materials;
- conduct presentations at senior centers and health fairs, and staff tables at various community events;
- use program enrollment sites outside of the welfare offices;
- provide home visits for application assistance; and
- employ a consulting firm to conduct an evaluation follow-up telephone survey of MSP enrollees.

Demonstration and pilot areas

- pilot a shortened application.

Minnesota's initiative focused on dual eligible elders in six counties, many of whom live in isolated rural areas. Pennington, Polk, Stearns, Sherburne, Goodhue and Fillmore counties were targeted for this grant. In addition to the six counties that received the full combination of outreach efforts, there were also eight counties that only piloted a shortened application form. These efforts were combined with a statewide media advertising campaign. A unique feature of Minnesota's program was the linkage between the QMB/SLMB[1] programs and the State's Prescription Drug Program. The MSP are offered as an add-on benefit when people apply for prescription drug coverage.

State partners included two divisions within the Minnesota Department of Human Services: the Division of Health Care Eligibility and Access, which directs counties in eligibility determination for all Minnesota health programs, including MinnesotaCare (Minnesota's

[1] In Minnesota, SLMB is called Service Limited Medicare Beneficiary program.

Medicaid program), the Prescription Drug Program and the MSP; and the Division of Aging and Adult Services, which is responsible for adult protective services and aging services not funded by the Older Americans Act. Aging and Adult Services Division activities are closely integrated with those of a third State partner, the Minnesota Board on Aging (BoA), a 35-member board appointed by the governor to oversee implementation of the Older Americans Act programs in the State. The Board is the State Unit on Aging, responsible for designating AAAs and allocating Older Americans Act funding. The Aging and Adult Services Division provides staffing to the BoA, and its Director is Executive Director of the Board, ensuring close coordination between the activities of the Board and the Division.

The goal in partnering with different organizations was the creation of an outreach team, where every member had a specific function. Health Care Eligibility and Access and Aging divisions worked on the development and distribution of outreach and promotional materials, coordinated efforts with various advocacy groups and worked with consulting firms on social marketing. The Minnesota BoA, together with several county social service boards, coordinated efforts with Health Insurance Counselors (HIC), Meals-on-Wheels and other organizations under their management. County social service agencies arranged and coordinated home visits by financial workers and HIC, as well as provided training to AAAs on the application process and assistance.

Three regions were chosen for the demonstration. Within each region an AAA and two counties implemented the grant. Figure D-1 in the Appendix D presents the State map and outlines the demonstration counties. In Minnesota, some AAAs operate a Senior LinkAge Line, an 800-number for information on aging and insurance related programs, and the State Health Insurance Assistance Program (SHIP). The SHIP runs a network of HIC volunteers, who provide free counseling to seniors about their health insurance options. Counties with the Senior LinkAge Line and a strong SHIP program were chosen for the demonstration. Local partners included senior centers, meal sites/meals-on-wheels providers, senior housing, churches, businesses, and other local organizations.

The State set a goal of enrolling 20,000 rural beneficiaries with an emphasis on isolated elders. Since the MSP in Minnesota are tied to the Prescription Drug Program, the State expected to capitalize on the attractiveness of the prescription benefit to elders and set an ambitious goal for enrollment in the MSP. The State chose three regions that were characterized as rural. One of the regions (7W) included the city of St. Cloud, which has a population of more than 40,000 people. Other than St. Cloud, the regions are sparsely populated tracts of farmland. The regions are also geographically distributed across the State: Region 1 was in the northwest, Region 7W in the center and Region 10 in the southwest. The BoA suggested regions where the AAAs had existing working relationships with the counties.[2] Although AAA regions consisted

[2] Minnesota is a 209(b) State. When an individual is eligible for SSI in 209(b) States, the individual must apply separately for SSI and for Medicaid, whereas in other States, individuals are automatically enrolled in Medicaid when they become eligible for SSI. Since the counties would have to work closely with the AAAs on any outreach effort to sign up SSI beneficiaries for Medicaid, the State chose regions where they felt that both the AAA and the counties would be receptive, and where there already was a reasonable working relationship.

of multiple counties, only two counties in each region were selected to work with the AAA on the demonstration.

Many barriers to enrolling in the MSP were identified by DHS prior to the grant. There was a welfare stigma associated with County Social Services where seniors had to apply for the programs. Many elders simply lacked knowledge that the programs existed, and this was exacerbated by the remote, isolated location of many eligible elders. In addition, estate recovery, known locally as the placement of liens, was a large barrier. The income limit also made many elderly ineligible for the programs. In particular, income from a "contract for deed," in which a home or farm is sold (often to a family member) in return for scheduled payments, is generally counted as income and places many elders slightly over the limits for MSP. This arrangement is common in Minnesota, especially in rural areas, where land is often a part of the homestead. Despite the fact that the asset limit was increased significantly in the year 2000,[3] this too remained a significant barrier. Informants also reported that recertification every 6 months is burdensome for program enrollees, and the re-certification letter is confusing.

To inform elders about the MSP, the State uses Leads Data received from the Social Security Administration (SSA) identifying new Medicare beneficiaries. The Buy-in Unit of HCEA then sends letters to the beneficiaries notifying them that they may be eligible for the MSP. To apply for the MSP, elders must complete a 28-page application. Most of the application does not apply to the MSP, as there is one application for all means-tested programs. Elders can either submit the application by mail or apply in person at the County Social Services Office.

Recertification is required every six months. The income and asset verification used for the initial application is requested again, together with the additional Income and Asset Renewal form. A recertification notice is mailed to beneficiaries, and a final "warning of termination" is mailed if there is no response. Elders can either recertify by mail or in-person at the county office.

4.2 Program Implementation and Operation

Although awarded the grant in October 2000, the State could not implement the program until it received legislative authorization in February 2001. The State partners then met to select demonstration areas and began working with the selected regions in March 2001.

The State employed two consulting firms to assist with the grant. One firm conducted a background literature review to identify effective methods of outreach to elders and their families and advised the State in preparation of marketing materials and its media campaign. The second firm conducted a post-grant random phone survey of MSP participants to assess the effectiveness of outreach efforts.

[3] Effective October 1, 2000, Minnesota increased the asset limit to $10,000 for a single person and $18,000 for a couple. The limits had been $4,000 and $6,000 prior to that, consistent with the federal rules (two times the SSI standard).

The State piloted a shortened application in the demonstration counties and in 8 additional counties. The new application collects only information needed for Medicaid, the MSP and for the State's Prescription Drug Program. The State and counties agreed that the shorter application was a major inducement for counties to participate in outreach, since the form was easier for financial workers to process. SHIP workers were also pleased with the new form, a copy of which is in Appendix D.

The State also provided central support for outreach efforts through the production of brochures and other promotional materials (posters, jar openers, door hangers, magnifying glasses). Examples of these materials are contained in Appendix D. These materials were customized for each region with local contact information. In all marketing materials, beneficiaries and interested persons were directed to the Senior LinkAge line, a toll-free information and assistance number that connects callers to their local AAA. LinkAge staff triaged calls, with the Prescription Drug Program and MSP inquiries directed to SHIP staff whenever possible. HIC counselors explained the programs, offered assistance with the applications and mailed them out together with informational brochures. The County tracked these applications from the AAAs.

A statewide television campaign in the form of paid advertising segments was produced and implemented by the State. It ran for two months (April to June of 2001). However, the campaign was not targeted solely at MSP because the State combined resources from this grant and from a Medicare fraud grant to produce an integrated campaign. Ads generally included 3 messages, promoting the State's Prescription Drug Program, QMB/SLMB, and prevention/reporting of Medicare fraud.

The State also developed a radio campaign that was launched in the summer of 2001. Based on the success of a previous radio campaign for the Prescription Drug Program, State and local officials believed radio would be more effective than TV. The radio and newspaper ad campaign began in the middle of June and ran until the end of August, targeting only the six demonstration counties. This campaign also used the number for the Senior LinkAge Line in its ads.

While the State has not done the official evaluation of the radio campaign, the informants reported that it was fairly successful and that enrollment rose during the time period the campaign was running, and continued to increase for the month or so afterward. When AAA staff asked beneficiaries where they heard about the MSP programs, many reported that it was radio. While radio ads were perceived by informants as somewhat more effective than a TV campaign in reaching isolated elders, they also reported that elders still had trouble writing down the telephone number from the radio ad. The State was pleased with the contracting agency's work with the key radio stations in the target areas to disseminate the ads. Many free radio interviews and public service announcements based on the paid ads were run at these stations.

While the TV media campaign for this grant was statewide, other initiatives were limited to the three regions targeted for the grant. The AAAs in each region developed their own outreach efforts. Examples of outreach efforts led by AAAs included:

- educating public health nurses and parish nurses about the MSP;
- appearing on local cable talk shows;
- placing articles in AAAs' quarterly newsletters, locals newspapers, and inserts in church bulletins;
- placing advertisements in local and religious newspapers, and in coupon books;
- sending letters to newspaper editors;
- sending out flyers with home-delivered meals and to meal sites;
- providing information to hospital and nursing home discharge workers and to the Independent Living Center;
- making informational presentations at senior centers, churches, meal sites, and clinics;
- meeting with county and agency representatives;
- providing informational materials to pharmacies, clinics, and on transportation; and
- staffing tables at banks and grocery stores.

Pharmacists were cited as being particularly helpful in disseminating MSP materials. They welcomed the display of informational posters with tear-off cards in their stores. The pharmacists may have a particularly strong interest in promoting the MSP as the Prescription Drug Program and SLMB have the same income and asset levels. Hence, one program is promoted as a complementary benefit to the other.

While all regions intended to conduct home visits, in Region 7W more in-home assistance was available because the demonstration counties had senior advocates who performed similar types of outreach and assistance. The AAA director in Region 7W estimated that approximately two-thirds of all applications were completed with in-home assistance. Other regions were constrained by scarce time and financial resources in the number of home visits they could make.

Other efforts were geared towards removing some of the stigma associated with the welfare nature of the MSP. SHIP volunteers offered application forms and assistance with the application process at such non-governmental sites as churches, libraries, pharmacies, clinics, congregate dining sites and grocery stores.

To assess awareness about the MSP in the demonstration counties, DHS contracted with a consulting firm to develop a questionnaire and conduct a telephone survey of 151 residents, who were in the DHS client database. The survey was fielded in March 2002 and included questions on demographics, preferences for and use of various media sources, MSP and

Prescription Drug Program awareness, assessment of the Senior LinkAge Line, and experience with the application process. The results of the survey were tabulated and reported back to DHS in April 2002. These are summarized in the following section.

4.3 Program Enrollment and Cost Impacts

Tracking Data

The State reported data on calls to the Senior Linkage Line resulting from the media outreach campaign. Based on these data, the efforts were not entirely successful. For example, DHS reported that during the time that the TV commercial was aired, a total of 7,682 calls were taken across the State, but only 171 (2%) calls could be attributed to the ad. However, tracking information was not collected for 2,522 calls (38.2%). Fourteen people reported radio ads as a source of information on the Senior LinkAge Line. The AAAs also tracked applications to the MSP that resulted from calls to the Senior Linkage Line. Of 2,048 calls for information, 203 people (10%) requested an application, 81 submitted an application and 27 requested assistance from the SHIP counselor in filling out an application.

HCEA also tracked the changes in processing time since reducing this was one of the State's goals for the grant. According to State-supplied data, by the end of the grant period the processing time was cut by about 10 days on average, from a month to about 20 days.

Additional information about the effectiveness of the grant can be gleaned from the evaluation survey of 151 MSP beneficiaries, which was conducted by a subcontractor to HCEA. Some of the findings were different from those reported by informants during our site visit. While most of the informants reported that the TV advertising campaign was the least effective and most expensive outreach strategy used, 79% of beneficiaries sampled identified television as the best way to reach them with information about MSP. Almost 16% reported TV as a source of information about MSP, 15% learned about the programs from their physicians, and less than 1 % from radio ads. The most important information sources were friends, relatives and neighbors, accounting for 29% combined. Only three persons received their information about MSP from the promotional items.

About two-thirds of the beneficiaries surveyed reported having difficulty completing the MSP application form due to confusion or health-related problems, and over 50% of all respondents received help in filling out the application. Most of the help came from family and friends and only 3 persons reported receiving help from an AAA.

Finally, the State reported enrollment growth of 7% in the demonstration counties, 4% in the pilot counties where only the new application was introduced, and a 2% increase in the other 73 counties of the State for the period from December 2000 through December 2001. This is consistent with the varying intensity of outreach activities by region during the grant program (greatest in the demonstration counties and least outside of the demonstration and pilot areas).

Medicaid Eligibility Data

State-supplied Medicaid eligibility data were analyzed for enrollment trends over the baseline and grant periods. The baseline period spanned 12 months (October 1999 through September 2000) and the grant period was measured over 15 months (October 2000 through December 2001). Since Minnesota Medicaid eligibility files may contain several monthly records per person representing different program eligibility categories, we developed an algorithm to assign each person to the program with the broadest benefits.[4]

To evaluate the effectiveness of the outreach in the demonstration areas, we defined control counties for comparison, which are similar in geographic and population characteristics to six grant counties. All rural counties in Minnesota outside the grant served as controls, including the pilot counties.

The table presenting statewide enrollment changes (Table 4-1) is organized as follows. The first two columns show the percent distribution within each category (e.g., gender, age, and race) for the baseline and grant periods, respectively. For example, in the baseline period 36.8% of the dual eligibles were under 65 years of age, whereas 39.6 % of dual eligibles fell in this age group during the grant period. The third column shows the percent change in enrollment from the baseline to the grant period for dual eligibles overall and for subcategories of eligibles. For example, in the under 65 age group there were 33,611 person-years of enrollment during the baseline period and 38,787 person-years in the grant period (data not shown). This corresponds to the 7.6% increase for this group shown in Table 4-1. It is possible for the percent distribution in a given sub-category to decrease from the baseline to the grant period even though enrollment in that sub-category grew over time in absolute numbers. This could occur if there is proportionately greater growth in other subcategories. Similarly, we could observe an increase in the percent distribution despite a decrease in enrollment if other groups experienced a relatively greater decrease in enrollment.

[4] The algorithm used the following hierarchy:

- All records with Medicaid as a major program and no SLMB coverage were assigned to the SSI category;
- All remaining records with QMB as a major program and no full Medicaid coverage were assigned to the QMB category;
- All remaining records with SLMB as a major program and no full Medicaid coverage were assigned to the SLMB category;
- All remaining records with SLMB and Medicaid coverage in the same month were assigned to the Medically Needy category;
- All remaining records with QDWI as a major program and no full Medicaid coverage were assigned to the QDWI category; and
- All remaining dual eligibles for whom the program could not be assigned were grouped into the "other" category.

Table 4-1

Statewide Changes in Dual Eligible Enrollment and Beneficiary Characteristics

	Minnesota		
	Baseline Period	**Grant Period**	**% Change[1]**
# of Person-Years	91,304	97,947	7.3
# of Unique Enrollees	110,475	124,783	13.0
	%[2]	%[2]	
Age			
<65	36.8	39.6	15.4
65-74	19.1	19.3	8.6
75-84	23.1	23.3	8.2
85+	21.0	17.7	-9.2
Gender			
Male	35.5	35.9	8.6
Female	64.5	64.1	6.6
Race			
White	86.0	84.5	5.4
Black	4.4	4.5	9.5
Asian/Pacific Islander	3.7	3.8	9.3
Native American	1.7	1.7	6.4
Unknown	4.2	5.5	40.8
Area of Residence			
Urban	59.7	59.4	7.0
Rural	40.4	40.6	8.0
Program Eligibility			
SSI	77.1	74.6	3.9
QMB	2.4	1.6	-28.8
Medically Needy	2.8	2.6	-0.5
SLMB	8.1	8.6	13.2
QDWI	0.0	0.0	-81.8
QI-1	0.8	1.1	49.2
Other	8.9	11.6	39.7

NOTES:

[1] Percent change in person-years of enrollment from baseline to grant period.

[2] Percent distribution within category. Numbers sum to 100% percent within category in each year.

SOURCE: HER analysis of Minnesota Enrollment Data, October 1999-December 2001.

Statewide trends in enrollment in the MSP are shown in Table 4-1. Compared with the baseline period, person-years of enrollment increased by 7.3% during the grant period. The number of unique individuals enrolled in MSP program was 13% higher during the grant period compared to the baseline.[5] All other enrollment trends are reported in person-years. The change in program enrollment varied by age: while person-years of enrollment for those under 65 years of age increased by 15.4% and for those in the 75-84 age group by 8%, there was a decrease of 9.2% among those aged 85 and over. While enrollment for White people was up 5%, there was also a 9% increase in enrollment of Black people and Asians and a 6% increase for Native Americans.

The largest enrollment increase was for the QI-1 program (49.5%), followed by SLMB (13.2%). Enrollment in QMB program fell by nearly 29%, though the actual changes are small because a fairly small percentage of dual eligibles were classified as QMB. SSI and Medically Needy programs also experienced drops in enrollment.

Figure 4-1 displays enrollment trends from the baseline period to the grant period. The blue line on Figure 4-1 charts the statewide enrollment trend. The increase in enrollment between September and October 2000 drives most of the statewide increase in the total number of dual eligibles enrolled. Since the grant implementation was delayed and did not start until after February 2001, this increase cannot be attributed to the outreach efforts and is probably due to the statewide change in the asset limits for MSP (beginning October 1, 2000, the limits were raised to $10,000 for a single person and $18,000 for a family of two or more). There is a slight downward trend in the last two months of the grant period.

Figure 4-1 also compares enrollment trends for the 6 demonstration counties where the grant paid for specific outreach activities (Regions 1, 7W and 10) and all other rural counties in the State (control area). There were no major differences in the slope of both lines, although the control area enrollment has a slight upward tendency while demonstration area seems to remain flat. While informants reported increases in MSP enrollment in the summer of 2001 following the radio campaign in the demonstration counties, we could not detect any related changes in the monthly numbers of MSP enrollees. The enrollment trends for the baseline and grant periods by program eligibility category are presented in Figure D-1 in Appendix D.

Table 4-2 compares changes in MSP enrollment between the demonstration and control areas. There is a greater increase in overall MSP enrollment in the 6-county demonstration area compared to the control (11.4% versus 7.9%). When examining the differences in growth by demographic characteristics between the demonstration and control areas, no obvious trends are visible. The demonstration areas show somewhat greater growth in 65-74 and 75-84 age groups and less of a decline in enrollment in the oldest age category. Demonstration areas also show slightly greater growth in enrollment of Asians and Native Americans, but less growth in

[5] Unlike person-years of enrollment, we cannot adjust the count of unique enrollees to account for differences in the length of the baseline and grant periods. As a result, comparison of the number of unique enrollees in the baseline and grant periods overstates enrollment growth.

Figure 4-1

Minnesota: Number of Enrollees by Month, Demonstration and Control Areas
(October 1999 - December 2001)

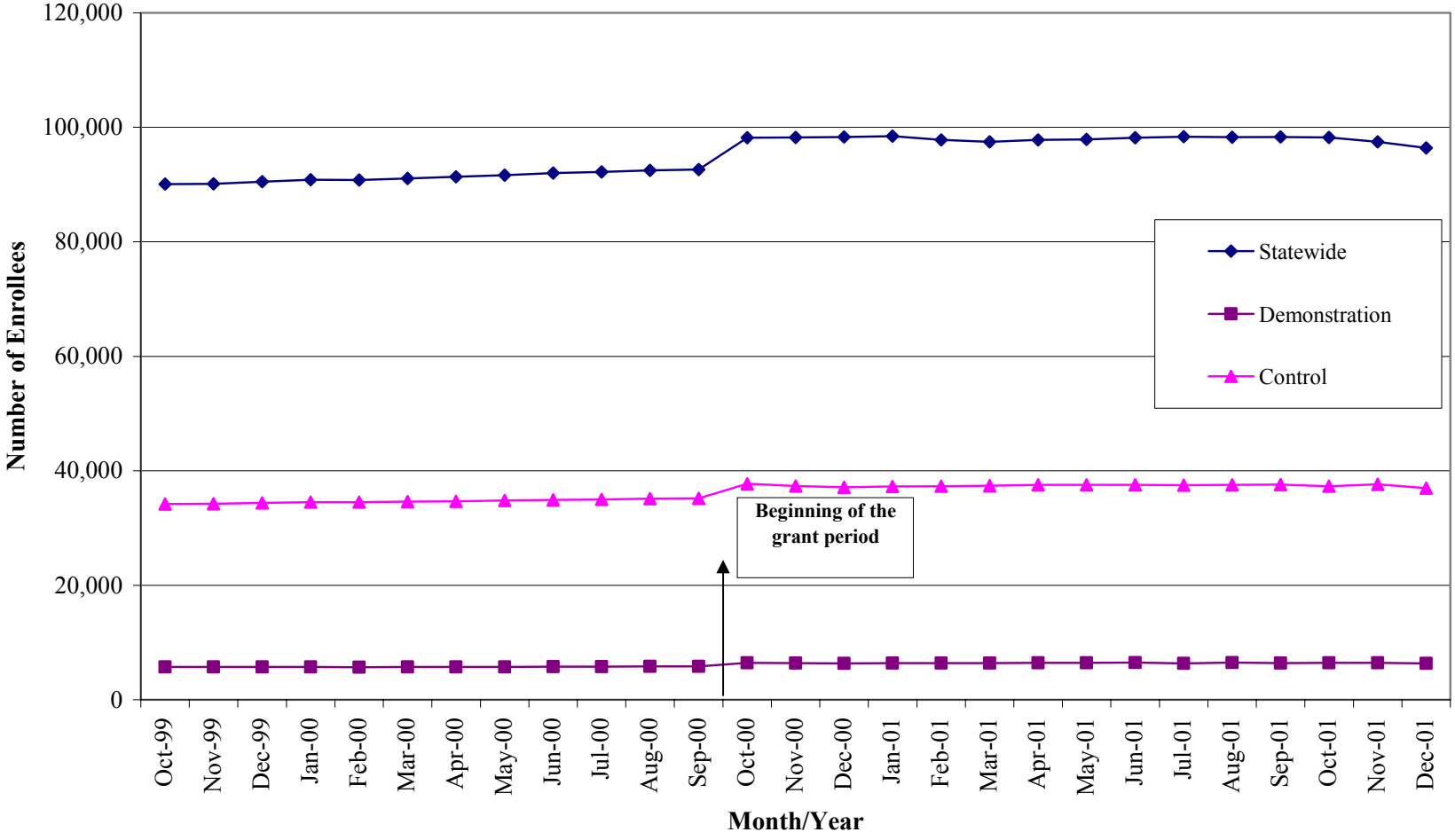


Table 4-2

Changes in Dual Eligible Enrollment and Beneficiary Characteristics, Demonstration and Control Areas

	MINNESOTA						
	Baseline Period		Grant Period		% Change[1]		Difference in % Change
	Demonstration Area	Control Area	Demonstration Area	Control Area	Demonstration Area	Control Area	
# of Person-Years	5,759	34,688	6,416	37,414	11.4	7.9	3.5
Age	%[2]	%[2]	%[2]	%[2]			
<65	33.1	30.8	34.2	33.0	15.0	15.7	-0.7
65-74	16.7	18.9	17.6	19.3	17.5	10.3	7.2
75-84	24.7	25.6	26.2	26.5	18.3	11.7	6.6
85+	25.6	24.7	22.1	21.1	-3.8	-7.7	3.9
Gender							
Male	33.8	35.1	33.9	35.5	11.7	8.9	2.8
Female	66.2	64.9	66.1	64.5	11.3	7.3	4.0
Race							
White	94.6	93.5	92.0	91.8	8.4	3.5	4.9
Black	0.6	0.2	0.5	0.3	5.0	13.5	-8.5
Asian/Pacific Islander	0.5	0.5	0.5	0.5	13.1	9.1	4.1
Native American	0.6	2.4	0.7	2.4	15.9	6.5	9.4
Unknown	3.7	3.4	6.3	5.1	89.0	62.8	26.2
Program Eligibility							
SSI	75.1	77.8	70.1	73.5	3.9	1.9	2.0
QMB	2.7	3.0	2.6	1.8	5.7	-33.2	38.9
SLMB	4.7	2.9	3.8	2.9	-9.0	7.0	-15.9
Medically Needy	7.8	5.9	8.8	7.0	25.6	26.3	-0.7
QI-1	0.7	1.0	0.8	1.4	30.2	60.1	-29.9
Other	9.0	9.5	14.0	13.5	72.7	53.0	19.7

NOTES:

[1]Percent change in person-year of enrollment from baseline to grant period.

[2]Percent distribution within category. Numbers sum to 100 percent within category in each year.

SOURCE: HER analysis of Minnesota Medicaid Eligibility Data, October 1999-December 2001.

enrollment of Black people. We did not compare the change in enrollment by urban and rural areas because both the demonstration and control areas were both rural.[6] There was a 5.7% increase in enrollment in the QMB program in the demonstration counties, which contrasted sharply with a 33% drop in the control area. The situation is reversed for the SLMB program: there was a 7% increase in enrollment in the control area, but an almost 9% drop in SLMB enrollment in the demonstration area. The demonstration area has only half the increase in enrollment in the QI-1 programs observed in the control area. When comparing percent changes in enrollment, it is important to keep in mind that the actual number of enrolled individuals can be small. For example, a 30% increase in enrollment for the QI-1 program in the demonstration area signifies a change from 38 person-years to 49 person-years.

Enrollment growth calculated by RTI from Medicaid eligibility date is greater than that reported by the State. The State reported a 7% enrollment increase in the demonstration counties, a 4% increase in the pilot counties, and a 2% increase in the other 73 counties, RTI's analysis of the Medicaid eligibility data shows an 11.4% increase in MSP enrollment in demonstration counties, a 7.6% increase in the pilot counties, and a 6.9% increase in the other 73 counties. This discrepancy can probably be attributed to the differences in the measurement periods. The state compared enrollment in December 2001 with December 2000, while RTI's calculation compared the baseline and grant periods. However, the RTI analysis confirms the State's finding that enrollment growth was greatest in the demonstration counties, followed by the pilot counties.

Table D-1 in the Appendix D examines the differences in enrollment changes between regions within the demonstration areas. Region 1 experienced an 8% increase in enrollment, region 7W a 16% increase, and region 10 almost an 11% increase.

Cost Data

The overall cost for the outreach grant was $362,329, which included $175,130 in federal funds and $186,447 in State matching funds and other expenditures. Region 1 received $79,070 in total, region 7W - $74,205, and region 10- $89,248 (totals include various state expenditures proportionately allocated to each region). Slightly over $40,000 each was spent on the statewide television campaign and promotional materials. Social marketing efforts cost over $37,000.

Table 4-3 presents data on the cost effectiveness of the Minnesota grant program. Ideally, cost effectiveness would be calculated using the number of new enrollees directly attributable to the grant initiative. However, data were not available on the number of new enrollees associated with grant initiatives. Therefore, cost effectiveness was calculated using Medicaid eligibility data only. It is important to note that when cost-effectiveness is calculated for the whole State in total, all enrollment increases are attributed to the grant in the absence of any controls. When cost-effectiveness is calculated for the demonstration area, the rest of the State serves as a control. The total program cost of $362,329, including State matching funds, was applied. There

[6] While region 7W is considered rural, the US census identifies the whole area as urban due to inclusion of the town of St. Cloud.

Table 4-3

Minnesota
Program Costs and Cost-Effectiveness

	Program Costs			Overall Increase in Enrollment	Cost-Effectiveness
	Federal	State Other [1]	Total[2]	Eligibility Data	Eligibility Data[3]
	$	$			$
Total	$175,130.00	$186,447.00	362,329	6,643	55
Total Demonstration Area	99,444	143,079	242,523	657	369
Region 1	31,210	47,860	79,070	-	-
Region 7W	30,944	43,261	74,205	-	-
Region 10	37,290	51,958	89,248	-	-
Statewide Media Campaign	8,158	34,000	42,158	-	-
Statewide Promotional Materials	32,650	7,420	40,070	-	-
Social Marketing	34,878	2,700	37,578	-	-

NOTES:

[1] The funds in "Other" category include funds from Medicare FYI grant.

[2] Total costs include allocation of administrative costs, indirect charges and in-kind state contributions.

[3] Eligibility data are reported in person-years.

SOURCE: HER analysis of Minnesota Medicaid Eligibility Data, October 1999-December 2001.

was an increase of 6,643 person-years between the baseline and grant periods. Overall, the cost of outreach was $55 per beneficiary enrolled. When only demonstration areas costs are considered, the cost of outreach was $369 per beneficiary enrolled.

4.4 Conclusions

The State of Minnesota sought the following objectives in pursuing the grant: to locate, inform and enroll elders residing in rural areas into MSP and to foster collaborations across state and county organizations that serve low-income elders. In every region, informants cited the relationship between the AAA and the counties as a successful program feature that would be valuable in future collaborative efforts. This was facilitated initially by the State, which hosted a kick-off meeting in each region to introduce the parties and explain the goals of the demonstration. At the State level, the two major agencies involved (HCEA and BoA) reported a parallel benefit of closer working relationships, which extends to other programs beyond the MSP.

The shortened application form was praised universally. Everyone interviewed acknowledged that the new form is much easier and less intrusive. In addition, as a result of the general education on MSP, county officials in one region (7W) reported that the applications they receive are more complete and accurate because the AAA better understood program requirements and documentation needs. Shortening the time for processing applications was one of the original State goals for the grant. With introduction of the shortened and revised application, this goal became a reality.

While the information on MSP was widely available throughout the State, based on the site visit interviews and our analysis of the enrollment data, there appears to be a small positive overall effect on statewide MSP enrollment. There is a 7.3% increase in the statewide overall enrollment between the baseline and grant period, which represents about 6,600 new MSP enrollees, far below the State's goal of enrolling 20,000. This surge in enrollment coincides with a major increase in the program's asset limits, which probably drives most of the overall enrollment gains in the grant period. While most of Minnesota's outreach activities were targeted to 6 demonstration counties, such important efforts as TV campaigns and publications were distributed statewide. As a result, both statewide and regional numbers should be considered in this evaluation. Region 7W experienced the greatest increase in enrollment (16%) compared to other two regions. Additionally, when the individual programs are examined, the SSI and Medically Needy programs experience a small increase after June 2001, which coincides with the media campaign. However, no similar effect can be found among QMB or SLMB programs.

The outreach efforts in Minnesota also included local AAA and Senior Linkage Line involvement in the six demonstration counties. These six demonstration counties (regions 1, 7W and 10) were compared to all other rural counties in Minnesota to determine whether efforts on the local level produced additional gains in enrollment. Growth in overall MSP enrollment was greater in the demonstration counties than in the control area comprised of all other rural counties in Minnesota (11.4% versus 7.9%, or 3.5% higher in the demonstration counties).

Timing issues were central to the implementation of the grant. The grant began late due to the necessity of legislative approval. In addition, the State had difficulty getting promotional materials to the regions. Regions were reluctant to begin aggressive outreach without the materials on hand. Also, the timing of the statewide TV campaign was not closely coordinated with regional outreach efforts, so local follow-up and reinforcement of the TV ads did not occur.

There were some problems not addressed by the grant, such as estate recovery. In addition, at least one region believed that the re-certification letters were too technical and that the language could be more inviting and easier to understand. They also believed that recertification should be required annually rather than every 6 months to reduce the number of disenrollees. Disenrollment patterns could not be studied for this evaluation due to data limitations.

The statewide television campaign was universally considered ineffective, but the reasons reported by informants varied. Everyone agreed that the appropriate programs and time slots had been selected. Some felt that elders probably could not respond quickly enough to write down the advertised phone number. State officials believed that a two-week campaign was not long enough to saturate the market. However, they believed they would never have the funds to run a TV ad that would be able to saturate the market. The sample commercial had multiple messages in it (Medicare fraud, prescription drugs, Medicare costs), which may have further diluted the effectiveness of the ad. However, the post-grant beneficiary survey found that MSP enrollees report TV as the best way of delivering informational messages, even though only 16% actually learned about MSP from the TV ads.

Because very few dollars flowed to the regions for this demonstration, outreach was dependent on existing infrastructure at the AAAs. The two smaller regions (1 and 10), felt they were not able to keep up with regular duties, much less devote extensive time to targeted outreach. While AAAs planned to rely on SHIP volunteers for many outreach activities, they quickly realized that, while willing to do most of the work, the volunteers are reluctant to make home visits in the rural sparsely populated areas where long driving distances are common.

The program does not appear to be reaching many isolated seniors. Only in one region (7W) are home visits widely available, and many of the outreach venues (e.g., senior housing, pharmacies, senior centers) reach elders who are already connected to some kind of program or support. To the extent that the Senior LinkAge line is not associated with the counties, the program may be reducing the welfare stigma.

In Minnesota, QMB/SLMB is not generally marketed by itself, but rather as an add-on benefit when people want prescription drug coverage. Based on the 20,000 enrollment goal for MSP set by the State, there was universal acceptance of this strategy among informants as having great potential, yet it does not appear to have paid off in this state. State and local officials felt that the State's Prescription Drug Program was the biggest draw from a marketing perspective, and that it made sense to lead with that program and simultaneously qualify applicants for QMB/SLMB. One complication of this strategy, however, is that QMB/SLMB is

subject to estate recovery, while the Prescription Drug Program is not. Because the applications for the two programs are linked, some local officials were concerned that the estate recovery applied to QMB/SLMB discourages people from applying for pharmacy assistance. They recommended that the applications be separate.

Overall, home visits and individualized help with applications were useful in enrolling beneficiaries, but not feasible in truly isolated areas. The TV and radio campaigns were too expensive for a sustained effort. Both AAAs and HCEA were pleased with the newly developed cooperation between both organizations as it promoted better understanding of MSPs on both the beneficiary and organization levels.

CHAPTER 5
MONTANA

5.1 Program Overview and Background

The State of Montana pursued three types of outreach for dual eligibles with this grant. The State produced a video about the MSP, created a series of placemats for senior meal centers, and attended fairs and powwows to promote the programs. The goal was to increase enrollment in the MSP from 35-100% in the demonstration counties.

The grant was implemented throughout the State with the exception of eight counties (a map of the State is included in Appendix E, Figure E-1). Many of the counties included in the grant are sparsely populated and considered the frontier.[1] The average number of people per square mile in the grant counties is 2.6, which makes conducting outreach to this population quite challenging (Montana Department of Public Health and Human Services, July 2000). The grant focused on all potentially eligible persons in the specified counties, but with a particular emphasis on Native Americans.

Montana pursued this grant to conduct outreach and enrollment for dual eligibles for a number of reasons. Representatives from the State felt that Medicare Savings Programs (MSP) were an underused and well-kept secret, and that this grant was a good opportunity to "get the word out." The State also believed it was an opportunity to create new relationships with other agencies and organizations, especially Native American Tribes. Native Americans have a low participation rate in Medicare and also in the MSP. Montana has a number of Native American Tribes and was interested in pursuing new outreach strategies for the MSP. The State had recently worked with the Native American Tribes to increase their participation in the State Children's Health Insurance Program, and they hoped to further these relationships.

There were partners at both the State and local levels. At the State level, the lead agency was the Human and Community Services Division Public Assistance Bureau, a part of the Montana Department of Public Health and Human Services. Other partners included the State Health Insurance Assistance Program (SHIP), the Social Security Administration, the American Association of Retired Persons (AARP), Native American tribes, the Mountain Pacific Quality Health Foundation (the Medicare Peer Review Organization) and Blue Cross/Blue Shield (the Medicare Part A Contractor for Montana). They had the following roles:

- The lead agency was the Montana Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau. As the lead agency, the Department was responsible for implementing the grant activities (developing the video and placemats, conducting trainings and staffing booths at fairs and powwows) and monitoring the budget.

[1] The Census Bureau defines a frontier county as less than two people per square mile. The Office of Rural Health defines frontier as less than six people per square mile.

- SHIP was the primary partner at the State level and assisted with the grant and program planning. SHIP staff attended events and staffed booths.
- The Social Security Administration attended meetings and trainings, helped staff booths at events, and provided technical assistance and support on Native American issues through a staff person who is Native American.
- AARP staff attended events and staffed booths. The AARP also paid for all booth and tent fees at the powwows and fairs and provided outreach materials.
- Representatives of Native American Tribes arranged booth space at their powwows for the State and acted as liaisons for the State and Tribes.
- The Mountain Pacific Quality Health Foundation and Blue Cross/Blue Shield distributed information about the MSP during the course of health education presentations (e.g., cancer screening awareness). In return, the partners would distribute information about health education at fairs and powwows.

Partners at the local level included Area Agencies on Aging (AAAs), county offices of public assistance, local Department of Public Health and Human Services and SHIP offices. The State also worked with the American Indian Institute at the University of Oklahoma to design the placemats and collaborate on the video script. The video was filmed by the Montana State University Film and TV Department.

The State identified a number of barriers to enrollment in the MSP. First, many people are simply unaware that the programs exist. For those who know about the programs, estate recovery is a large barrier, as it is actively pursued by Montana and seniors feel that the benefit was not worth risking their homes. Recovery is not, however, a barrier for Native Americans because the regulation does not apply to lands held in Tribal Trusts.

A second barrier is the remoteness of many seniors. As stated above, much of the State is considered the frontier. It is not unusual for people to live 40-50 miles from the nearest town and, since lack of transportation is also an issue, it is difficult for many elders to attend presentations to learn about these programs. However, the State has never required that beneficiaries apply for the MSP in person. Applicants for any Medicaid program can mail in applications with the proper income and asset verification. Because many Native Americans do not have birth certificates, the State accepts alternatives, such as baptismal certificates, census records and school records.

One barrier particular to enrollment of the Native American elders is that many are not enrolled in Medicare. There is a general belief that the Indian Health Service should take care of all of their needs. In addition, some Native Americans are quite suspicious of the federal government.

A general dislike of paperwork and bureaucracy was also cited as a barrier. Although interviewees in our site visit were loath to ascribe a welfare stigma to the MSP, they said there was a "Montana Pride," described as self-sufficiency and the ability to do without. There is also a fear that no one is ever anonymous in a small community.

To address some of these barriers, Montana introduced a shortened application form in June 2000 (a copy is included in Appendix E). Prior to this time, there was no separate application for QMB, SLMB, QI-1 and QI-2. There was only one generic application for all medical assistance and social services programs (e.g., Medicaid, TANF, food stamps, etc.). The State believed that by separating the application for the MSP from other programs, they would be removing any associated welfare stigma.

The application is now four pages long, in booklet format. It comes with a section describing the programs, income and asset guidelines, instructions and frequently asked questions. The cover of the application reads "Medicare Savings for Qualified Beneficiaries," and promotes word-of-mouth (to reach isolated seniors and reduce stigma) by asking potential applicants to share information about the MSP and, if the person does not use the application, to pass it along to someone who might.

Local SHIPs assist seniors with applications when needed. Seniors can either send originals of documentation with their application, or representatives will make copies for them to send. Applications are required by law to be reviewed within 45 days of receipt. The State reports it takes approximately 10-12 days in Montana.

Recertification is an annual process and involves completing a shorter 2-page application and release form. No verification of income and assets is required unless circumstances have changed from the previous year. The State believes that only occasionally are seniors disenrolled from the program because they have moved or they have forgotten to recertify.

5.2 Program Implementation and Operation

Montana chose three distinct activities to pursue with the outreach grant. They were the production of a video about the MSP, creation of Medicare-themed placemats for senior centers, and outreach at powwows and State fairs. Each is discussed in turn.

Video. The State produced a video about the MSP that focused on Native Americans with consultation from the American Indian Institute at the University of Oklahoma. The video featured a Native American woman, who works for a local Social Security office, explaining Medicare and the MSP to a Native American senior. It also gives a phone number, which, when called, will be routed to the local AAA. The video is conducted in English, as most Native Americans speak English, but is mindful of Native American culture and custom. Once completed, the Department of Public Health and Human Services distributed copies of the videos to their grant partners, community health centers, Indian Health centers, senior citizen centers, libraries and public service sections of video stores. Distribution began on December 31, 2001, the last day of the grant period.

Placemats. Five placemats were designed for use at senior congregate meal sites and for distribution with Meals on Wheels deliveries. The placemats were used to educate seniors about Medicare, and each contained a telephone number to call for more information. The mats were in color with a Native American motif for the border and pictures of beneficiaries.

The first in the series of placemats was entitled "What is Medicare?" The next themes included "What Does Medicare Part A Cover?" and "What Does Medicare Part B Cover?" The fourth placemat described the importance of Medicare for the elderly with a particular emphasis on its importance for Native Americans. The last placemat instructed readers on how to apply for "Medicare Programs." The placemats, copies of which are in Appendix E, were popular according to the State and were laminated by some centers for continued use.

Outreach at Powwows and Fairs. Because the counties that Montana targeted for this grant were so sparsely populated, the State needed to conduct outreach at gatherings where seniors would be in attendance – county fairs and powwows. The State attended 35 powwows and fairs during the grant period. Persons we interviewed indicated that the elderly may leave their homes only a few times a year and one of those times would be to attend these events.

The booths at the fairs and powwows were staffed by the State, county-based staff, AARP volunteers, and SHIP volunteers. Information about the MSP, applications and "giveaways" were distributed. The intent of the giveaways was to get information about the MSP into homes so that people would know whom to contact for more information. Examples included diabetic health records, magnifying glasses, jar grips and magnetic picture frames. The State also inscribed a slogan on some of the materials, "Let Us Pay Your Medicare Premiums." Copies of examples of the materials are included in Appendix E.

The State also displayed yo-yos and slinkies on the tables at the fairs and powwows, which attracted children. Because the fairs and powwows were family events, children were asked to bring their parents and grandparents back to the tables so that the representatives could discuss the programs with them. In addition, at each event, a drawing was held for a traditional wool blanket with Native American designs as an extra incentive to visit the booth. The tickets for the drawing included name and address, and the State used this to mail information about the MSP.

Miscellaneous Outreach Activities. In addition to the three main outreach activities undertaken with this grant, there were other activities to promote the MSP. Partners, including SHIPs and AARP, wrote articles for the local newspapers and their newsletters about the MSP. Local cable television programs highlighted the programs and interviewed representatives about them. Staff from the Department of Public Health and Human Services also conducted trainings at health clinics on the Native American reservations.

The Native American Tribe visited during the RTI site visit had particular success with conducting home visits to promote the MSP. The clinic staff accessed State eligibility records to determine who among their elder patients were eligible but not enrolled in the MSP, and these persons were targeted for one-on-one outreach in the home. This allowed the staff to connect personally with each senior and help enroll them in the programs.

5.3 Program Enrollment and Costs Impacts

Tracking Data

Montana did not collect tracking data from its initiatives. The initiatives included the production and distribution of placemats, the production and distribution of an informational video and outreach tents at fairs and powwows. In total, 36,885 placemats were given to senior congregate meal sites and the Meals on Wheels program in June and July 2001. According to the state's final report, over 300 videos were distributed, and over the summer, outreach was conducted at 35 fairs and powwows. The State approximates that "as many as 15,000 people throughout the summer and fall of 2001" were reached because of the outreach at the fairs and powwows (Montana Department of Public Health and Human Services, April 2002).

Medicaid Eligibility Data

We received aggregate monthly Medicaid eligibility data from Montana for October 1, 1999 through December 31, 2001 broken out by age, gender, race/ethnicity, county and program eligibility. All but eight counties in the State were part of the demonstration, and we used the remaining counties as a control.[2] Many of the demonstration area counties were considered frontier counties and the others were rural. The control counties were not included in the grant because they were considered urban.

The table presenting statewide enrollment changes is organized as follows (Table 5-1).[3] The first two columns show the percent distribution within each category (e.g., gender, age, and race) for the baseline and grant periods, respectively. For example, in the baseline period 15.6% of the dual eligibles were between 65 and 74 years old, whereas 16.3 % of dual eligibles fell in this age group during the grant period. The third column shows the percent change in enrollment from the baseline to the grant period for dual eligibles overall and for subcategories of eligibles. For example, in the 65-74 age group there were 3,644 person-years of enrollment during the baseline period and 3,898 person-years in the grant period (data not shown). This corresponds to the 7.0% increase for this group shown in Table 5-1. It is possible for the percent distribution in a given sub-category to decrease from the baseline to the grant period even though enrollment in that sub-category grew over time in absolute numbers. This could occur if there is proportionately greater growth in other subcategories. Similarly, we could observe an increase in the percent distribution despite a decrease in enrollment if other groups experienced a relatively greater decrease in enrollment.

Overall, there was a 2.8% increase in person years during the grant year. Beneficiaries age 65 and over experienced the largest increases: 7.0% for beneficiaries 65-74 and 8.8% for beneficiaries 75+. Enrollment of females increased slightly more than males. All of the racial

[2] The demonstration area consisted of the following counties: Lincoln, Sanders, Mineral, Beaverhead, Madison, Granite, Deer Lodge, Lake, Powell, Jefferson, Broadwater, Park, Meagher, Teton, Pondera, Glacier, Toole, Liberty, Choteau, Judith Basin, Wheatland, Sweet Grass, Stillwater, Carbon, Hill, Blaine, Fergus, GoldenValley, Phillips, Petroleum, Musselshell, BigHorn, Treasure, Rosebud, Garfield, Valley, Daniels, Sheridan, Roosevelt, McCone, Richland, Dawson, Prairie, Wibaux, Custer, Fallon, Powder River and Carter. The control group consisted of the remaining eight counties: Flathead, Missoula, Ravalli, Silver Bow, Lewis and Clark, Cascade, Gallatin and Yellowstone.

[3] We were not able to calculate the number of unique enrollees for Montana because the State only reported aggregate monthly enrollment data, rather than person level data (as was reported by other States).

Table 5-1

Statewide Changes in Dual Eligible Enrollment and Beneficiary Characteristics

	Montana		
	Baseline Period	**Grant Period**	**% Change[1]**
# of Person-Years	23,284	23,930	2.8
	%[2]	%[2]	
Age			
0-19	8.8	8.1	-5.1
20-64	52.2	50.9	0.2
65-74	15.6	16.3	7.0
75+	23.4	24.7	8.8
Gender			
Male	41.9	41.7	2.2
Female	58.1	58.3	3.2
Race			
White	85.5	85.8	3.0
Black	0.3	0.4	9.2
Hispanic	1.1	1.2	8.1
Asian/Pacific Islander	0.3	0.3	12.9
Native American	12.7	12.4	0.1
Area of Residence			
Urban	31.1	31.6	4.4
Rural	68.9	68.4	2.0
Program Eligibility			
SSI	45.5	45.3	2.4
QMB	45.0	44.2	1.0
SLMB	8.3	8.9	9.8
QI-1	1.0	1.3	36.8
QI-2	0.3	0.3	21.2

NOTES:

[1] Percent change in person-years of enrollment from baseline to grant period.

[2] Percent distribution within category. Numbers sum to 100 percent within category in each year.

SOURCE: HER analysis of Montana Medicaid Eligibility Data, October 1999-December 2001.

and ethnic groups experienced increases in enrollment, with the largest increases for minorities as opposed to whites. There was a somewhat greater increase in urban areas compared to rural.

All of the program eligibility categories experienced increases as well, with the QI-1 and QI-2 programs experiencing the highest growth (36.8 and 21.2%, respectively).

Table 5-2 displays the change in dual eligible enrollment and beneficiary characteristics from the baseline to the grant period comparing demonstration and control counties. The data show a 2% increase in person months in the demonstration area, while there was a 3.4% increase in the control area. It should be noted that the non-demonstration counties are not the optimal control group because they contain urban areas (56%) whereas the demonstration counties are 100% rural. However, no better alternative was available.

In the demonstration area beneficiaries age 65 and older experienced increases in enrollment, while those under 65 experienced small decreases. Females had slightly higher increases in enrollment compared to males. All racial and ethnic groups with the exception of Black people had increases in enrollment ranging from 0.5% for Hispanics to 20% for Asian Pacific Islanders. It should be noted that although some of the percentages are large, in many instances the absolute numbers are small. Most programs also had increases in enrollee person years. QI-1s had a 43% increase in person years, followed by 16.5% for QI-2s and 13% for SLMBs.

With the exception of individuals under the age of 20, all age groups experienced increases in enrollment in the control area. Enrollment among racial and ethnic groups increased with the exception of Native Americans in the control area. There was an increase in enrollment in all program eligibility categories in the control area as well.

The data indicate lower growth in the demonstration area compared to the control. With some important exceptions, this was true across all demographic groups. However, Native Americans, who were a specific focus of the outreach, experienced an increase in enrollment in the demonstration area, while they experienced a decrease in the control area. It is also notable that there is no difference in the growth rate when the demonstration area is compared to rural counties in the control area. Enrollment growth in both the SLMB and QI-1 programs was higher in the demonstration area, but lower for SSI, QMB and QI-2.

Figure 5-1 displays trend data for enrollment overall and by demonstration and control counties. All three lines exhibit steady increases in enrollment with neither large peaks nor large dips in enrollment. Placemats were put into use in June 2001 and continue to be used in some places today, but there does not seem to be a noticeable increase in enrollment associated with their introduction. Many of the outreach activities at fairs and powwows were conducted during the summer months, and there is a slight increase in enrollment during that time. Unfortunately, the video was not distributed until the last day of the grant period so any impact from that cannot be discerned. Individual program trends, which follow a similar pattern, can be found in Figure E-2, Appendix E.

Table 5-2

Changes in Dual Eligible Enrollment and Beneficiary Characteristics, Demonstration and Control Areas

	MONTANA						
	Baseline Period		Grant Period		% Change[1]		Difference in % Change
	Demonstration Area	Control Area	Demonstration Area	Control Area	Demonstration Area	Control Area	
# of Person-Years	10,294	12,991	10,504	13,426	2.0	3.4	-1.4
Age	%[2]	%[2]	%[2]	%[2]			
0-19	8.0	9.3	7.4	8.6	-6.0	-4.5	-1.5
20-64	49.8	54.2	48.4	52.9	-0.7	0.8	-1.5
65-74	17.5	14.2	17.9	15.1	4.0	9.9	-5.9
75+	24.7	22.3	26.3	23.5	8.8	8.7	0.1
Gender							
Male	42.0	41.9	41.9	41.5	1.9	2.4	-0.4
Female	58.0	58.1	58.1	58.5	2.1	4.1	-1.9
Race							
White	84.3	86.5	84.1	87.1	1.7	4.1	-2.4
Black	0.4	0.3	0.3	0.4	-2.4	19.7	-22.1
Hispanic	1.1	1.2	1.1	1.3	0.5	13.9	-13.4
Asian/Pacific Islander	0.2	0.4	0.2	0.4	20.2	9.7	10.5
Native American	14.0	11.7	14.3	10.8	4.2	-3.8	7.9
Area of Residence							
Urban	N/A	55.7	N/A	56.2	N/A	4.4	N/A
Rural	100.0	44.3	100.0	43.8	2.0	2.0	0.0
Program Eligibility							
SSI	45.2	45.6	44.9	45.6	1.2	3.3	-2.0
QMB	45.5	44.6	44.5	44.0	-0.2	2.0	-2.2
SLMB	7.8	8.8	8.6	9.1	13.0	7.5	5.5
QI-1	1.1	0.9	1.6	1.1	43.1	30.2	12.9
QI-2	0.4	0.2	0.4	0.2	16.5	29.2	-12.7

NOTES:

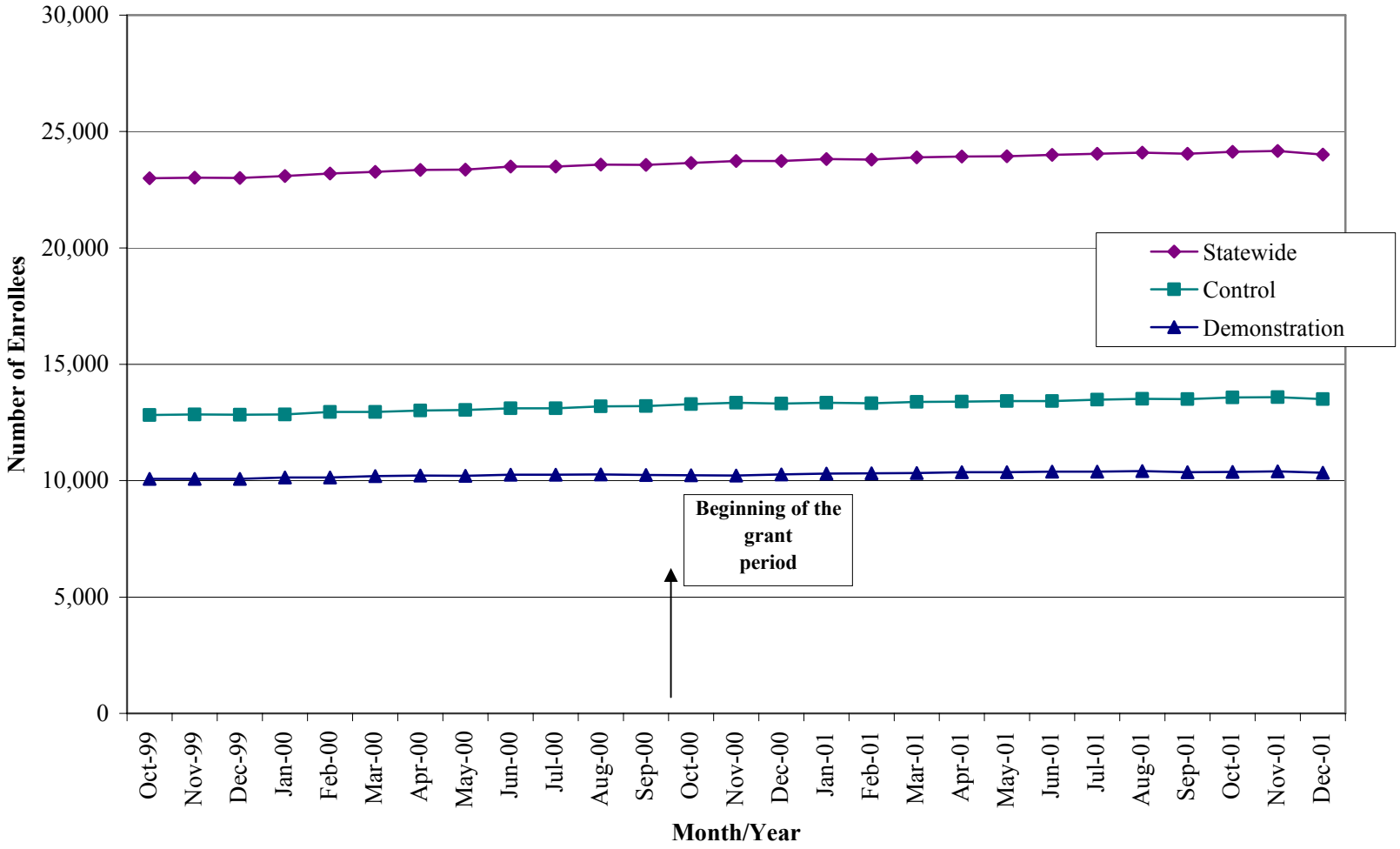
[1] Percent change in person-years of enrollment from baseline to grant period.

[2] Percent distribution within category. Numbers sum to 100 percent within category in each year.

SOURCE: HER analysis of Medicaid Eligibility Data for Montana, October 1999-December 2001.

Figure 5-1

Montana: Number of Enrollees by Month, Demonstration and Control Areas (October 1999 - December 2001)



Cost Data

Table 5-3 presents the cost data for Montana. Overall, the cost of the initiative was nearly $70,000, split between federal funds, State funds and funding from partners. The federal share was $47,253, the State share $4,673 and the partners' $17,187 (the largest contribution by the AARP of $15,207.06). We did not calculate the cost-effectiveness of Montana's grant program because, based on our comparison with control county enrollment, growth in the demonstration area was less than what would have been expected in the absence of the grant.

Table 5-3

Montana
Program Costs

	Program Costs		
	Federal	State	Total
Activity Cost	$	$	$
Events	23,359	2,310	25,669
Placemats	7,467	739	8,206
Video Production	16,427	1,625	18,051
Subtotal	47,253	4,673	51,926
Partners' Costs			
AARP	--	--	15,207
Mt.Pacific Quality Health Foundation	--	--	1,113
Social Security Administration	--	--	867
Subtotal	--	--	17,187
Total Costs			69,113

SOURCE: Clark NH. "Building Partnerships for Innovative Outreach and Enrollment for Dual Eligibles. " Final Report, Montana Department of Public Health and Human Services, April 11, 2002.

5.4 Conclusions

All partners believed that the grant was successful. The partnerships worked well at both the State and local levels and new relationships were forged with Native American Tribes. The Department of Public Health and Human Services planned to continue annual trainings about the MSP with current partners and with Tribes. They also planned to use existing partnerships to promote outreach and enrollment in other Medicaid programs.

In comparison to other States, a unique aspect of this program was Montana's focus on Native Americans, many of whom reside on reservations in the demonstration area. The State believed that the Tribes were generally appreciative of their efforts to promote Medicare and the MSP for their tribal members. Because the Tribes are individual entities, the State worked with each separately to train them about the program. The Tribes then educated their members as interviewees felt that Native Americans are more likely to respond to people they know. Staff at Indian health clinics also educated the elder Native Americans on the importance of Medicare for both themselves and the clinic as a way to increase access to physicians and provide another funding stream for the clinics. According to the Medicaid eligibility data, enrollment of this population increased by slightly more than 4% in the demonstration area, while it declined in the control area. This suggests that the demonstration may have been successful at reaching this target population.

Estate recovery remains a large barrier for the State to address. In educating seniors about the programs, staff tried to explain that they should take care of themselves (through the help of the MSP) so that their children would not have to. They explained that estate recovery was limited to Medicare premiums for the months in which they received assistance and any deductibles and coinsurance (if applicable). For some, this made them realize that the amount that would be recovered was not large relative to the value of their home.

Despite their best efforts, some partners believed that educating the elderly about these programs would always be difficult. Although the information has always been available, seniors often do not know how to ask for help. One suggestion was that more might be done through the cross matching of State and federal data bases on eligibility to target seniors specifically.[4] This would allow States to better target their outreach activities to those who may be eligible but unaware of the programs or do not know who to contact for assistance. Another suggestion was to educate providers about these programs so that they can inform their elder patients.

Montana's goal was to increase enrollment by a minimum of 35% in each of the demonstration counties. Overall, we found a 2% increase in enrollment in the demonstration area compared with a 3.4% increase in enrollment in the control area.

Based on our analysis of Medicaid eligibility data, we did not find that the grant increased enrollment in the MSP during the study period. Our comparison with control counties showed that enrollment growth in the demonstration area was lower than would have been expected absent the grant program. However, the control area was an imperfect comparison group because more than half of the population lives in urban areas whereas the demonstration area was entirely rural. Nonetheless, even limiting our comparison to rural areas of the control site, we did not find that the grant had a positive impact on enrollment. One explanation for this is that the outreach activities at the fairs and powwows may have had spillover effects outside of the demonstration area if residents of control counties attended these events and received the MSP information. Thus, our ability to isolate the effects of the grant on enrollment was limited.

[4] Eligibility data are available to States through Leads Data and States now have the option to obtain a customized extract of the EDB that they can match to their Medicaid eligibility data.

In addition, the impact of these initiatives, particularly the video, may be realized over a longer timeframe.

CHAPTER 6
TEXAS

6.1 Program Overview and Background

Shortchanged: Billions Withheld from Medicare Beneficiaries, a Families USA report, was a major impetus behind Texas pursuing the grant for enrollment and outreach of dual eligibles. It was from this report that the State learned that more than one-half of its eligibles were not enrolled in the programs. As a result, the Texas Department on Aging, in collaboration with the Texas Department of Human Services, sought all opportunities to fund outreach for these programs.

With this grant the Texas Department on Aging partnered with the Texas Department of Human Services and four Area Agencies on Aging (AAA) along the Texas-Mexico border (a map of the State is included in Appendix F, Figure F-1). The roles of each partner were as follows:

- the Texas Department of Human Services had overall responsibility for implementing the grant, providing training about the programs, and assisting with simplifying the enrollment process;
- the Texas Department on Aging, in conjunction with the Texas Department of Human Services, was responsible for choosing the 4 AAAs (which are funded by the Department on Aging). The Department on Aging was also responsible for collecting and analyzing data from the AAAs; and
- AAAs in El Paso, Carizzo Springs, Laredo and MacAllen were responsible for each hiring an outreach specialist to promote the MSP.

The participating AAAs were chosen as partners because they had an established infrastructure to assist the elderly in these regions. All four AAAs were willing to join in this outreach and enrollment effort, as they considered it a valuable funding stream to assist their clients.

The elderly along the Texas-Mexico border were the focus of this grant. It was estimated that there were 45,000 eligible, but unenrolled seniors, in the border regions, and the goal of the grant program was to increase enrollment by 4%, or 600 beneficiaries (150 from each region). The population is very poor, difficult to reach and, according to the State, has immense health needs. According to the Texas State Data Center's 2000 Projections, almost 25 percent of the elderly along the border are eligible for QMB/SLMB. The majority (63%) of the elderly are Hispanic and 35% are White people.

The elderly in this area face a number of barriers, including language barriers and a lack of available services. The Spanish spoken along the border differed by region, and the literacy rates for both English and Spanish are low. Some elderly live in *colonias*, which are unincorporated tracts of land that have no streets, no running water, no sewage systems and

limited electricity. Immigration is also a significant barrier. Often, either families or extended families had mixed immigration status, and seniors were afraid to enroll in programs for fear of deportation.

According to the advocates we interviewed, the application process is challenging for the elderly if they do not receive assistance. Many had difficulty gathering documents required to verify income because they could not find them or their children had them. In addition, life insurance policies are difficult to verify because often insurance companies are sold to other companies, which makes it a difficult and lengthy process to determine the cash value of the policy.

There is also a stigma related to applying for services at the local Department of Human Services' offices. Many elderly had difficulty getting to the offices. Then, once at the offices, they perceive the staff to be unfriendly and unhelpful. Many seniors do not understand the programs that they are applying for and feel that the Texas Department of Human Services' staff are uncommunicative and are not forthcoming with information and assistance.

To address some of the barriers, Texas began using a shortened application form for buy-in programs several years ago (a copy of which is in Appendix F), which was the result of a separate pilot program. The application is also available in Spanish. In 2000, Texas began allowing applicants to self-declare verification of their assets and resources. Verification is conducted through a third-party (e.g., banks, insurance companies) in the event the amount declared is within $10 of the income limit or $100 of the resource limit, or if the case worker feels third-party verification is required. Self-declaration was implemented because advocates had convinced the State that asset verification with supporting documentation was a major barrier to applying for the programs. Recertification for the programs is required annually, and the local Department of Human Services' offices are responsible for sending beneficiaries reminder letters.

6.2 Program Implementation and Operation

The State convened three meetings to discuss this grant with the AAAs. During these sessions, staff from the AAAs was trained about eligibility and enrollment for these programs. In addition, various issues were discussed including estates, trusts, the legality of transferring titles on property, and legal and appropriate means for beneficiaries to reduce their assets and resources.

Each AAA was responsible for hiring an outreach specialist to promote the MSP, and this caused the start-up time of the grant to vary somewhat across regions. The outreach specialist for the Rio Grande began in late November, while the specialists in the Lower Rio Grande and South Texas began in December and the one in Middle Rio Grande began in January. The outreach specialists also came from a variety of backgrounds. In particular, one outreach specialist had worked previously for the Department of Human Services; thus, she had been familiar with the MSP already.

The regions were given discretion in developing their own outreach activities. The 4 AAA regions vary in size in terms of area and population. The Rio Grande, Lower Rio Grande and South Texas AAAs all contain a Metropolitan Statistical Area (MSA) (the Lower Rio Grande contains two), while the Middle Rio Grande AAA region is largely rural. Each AAA faced the challenge of the sheer size of its region, as each covered numerous counties and could be thousands of square miles large.

Although the outreach specialists brainstormed with their own agencies to develop ideas, they also shared ideas with the other regions involved in the grant. As a result, there were many similarities in outreach activities across regions:

- interviews on radio stations, both American and Mexican;
- interviews on community cable channels, both American and Mexican;
- radio advertisements;
- advertisements in local newspapers and shoppers' guides;
- advertisements and brochures at pharmacies, restaurants, churches, etc.;
- direct door-to-door outreach; and
- staffing tables or making presentations at health fairs, churches, malls, schools, senior centers, housing authorities, nutritional centers, town hall meetings, disability groups, adult day care, food distribution sites and flea markets.

Most AAAs advertised in newspapers and posted brochures on bulletin boards in stores, groceries, pharmacies and restaurants – essentially wherever they were allowed. One AAA had a particularly positive response to an advertisement placed in the *Bargain Shopper*, a free newspaper with coupons. Another had good success giving brochures to Meals on Wheels drivers to pass along to their clients while delivering meals. In another region the AAAs trained *promoturas*, Vista volunteers in the rural areas, to educate beneficiaries and complete applications. One AAA set up a table at an intersection in a *colonia* for passers-by to pick up information. Outreach specialists also travel throughout the AAA regions conducting outreach, which is challenging because the regions can be thousands of square miles large. The outreach specialists were bilingual, and they typically knew the Spanish dialect spoken in the region.

Some of the AAAs designed their own outreach materials in order to portray local beneficiaries on the brochures and to reflect regional variations in language. AAAs also adopted slogans to catch the eyes of seniors. For example, one brochure asks, "Are you on Medicare? You could be saving $100s a Year!" Another AAA outside of the grant program area uses bumblebees to advertise the program, a portly bee being the "QMB," and a "slim" bee being the "SLMB." All outreach activities and materials were in both English and Spanish to overcome any language barriers. Examples of outreach material are included in Appendix F.

The AAAs found that the communities were generous with their time and support of this project. In one region, the outreach specialist was given office space at a public building with

use of phones and copiers. In another, an AAA received free advertising in the newspaper and free radio airplay.

The AAAs tried to make completing the application as easy as possible for the beneficiaries, although it proved to be a time intensive process. Specialists estimated it took between one and two hours to assist with each application. Because of the grant program, beneficiaries received help completing the application process that they had not received before. Beneficiaries did not have to visit the Texas Department of Human Services' offices to learn about the programs or to apply for them. Some outreach specialists gave beneficiaries addressed stamped envelopes to submit their applications, or they delivered applications to the local Department of Human Services' offices for beneficiaries. These efforts addressed the 'welfare' stigma and 'unfriendly' Department of Human Services' staff that beneficiaries felt existed.

6.3 Program Enrollment Impacts and Costs

Tracking Data

Table 6-1 displays the number of applications that were completed by the types of outreach the AAAs conducted in each of the four regions. Overall, 728 applications were completed by the 4 AAAs. However, the number of completed applications differed by region. For example, the Rio Grande AAA submitted 314 completed applications, while the Middle Rio Grande submitted only 110. This could be partially due to the variation in population density across the regions.

Use of the media (radio shows, cable TV interviews, newspaper ads, etc.) was the most effective method of advertising the programs, yielding the most applications in each of the four regions. In the Rio Grande, the media yielded 124 applications, in South Texas 45, in Lower Rio Grande 70 and in Middle Rio Grande 43. These numbers represent completed applications, but not applications certified as eligible.

The Rio Grande AAA submitted the most applications of the four AAAs (314). This AAA tried various types of outreach to promote the programs in addition to the media. Presentations or information provided at senior citizen centers, housing authorities and through the Social Security Office were also effective in yielding applications. Referrals and presentations or information at the colonia community centers were similarly effective in yielding applications in South Texas. The colonia community centers and senior citizen centers were also effective in gaining completed applications in the Lower Rio Grande, while senior centers were important locations to promote the programs in the Middle Rio Grande.

Table 6-1

Number of Applications Completed, by AAA and Outreach Activity
Texas

AAA	Outreach Activity	# of Applications Completed
Lower Rio Grande	Colonia Community Centers	32
	Media	70
	Not Specified	10
	Referral	3
	Senior Citizen Centers	36
	Total	151
Middle Rio Grande	Colonia Community Centers	9
	Health Fairs	5
	Media	43
	Adult Day Care	1
	Court house	5
	Family Member	2
	Food Commodity Site	1
	Friend	7
	Home Visit	1
	Hospital	1
	Housing Authority	3
	Library	1
	Nutrition Center	1
	Walk in	1
	Parish Halls, Church Facilities	5
	Senior Citizen Centers	22
	Texas Work Force	2
	Total	110
Rio Grande	Civic Group Sponsored	1
	Colonia Community Centers	3
	Grocery Store	2
	Health Fairs	8
	Media	124

Table 6-1 (continued)

Number of Applications Completed, by AAA and Outreach Activity
Texas

AAA	Outreach Activity	# of Applications Completed
Rio Grande (con't)	Other	2
	AAA	7
	AARP	1
	Adult Day Care	2
	Attorney General's	1
	Brochure	1
	Community Center	1
	Diabetes	1
	Doctor's Office	1
	Family member	1
	Flyer	1
	Friend	8
	Hospital	1
	Housing Authority	25
	Inquiry on Medi groups	1
	Insurance	1
	Insurance Information	2
	Medicare Seminar	5
	Not Specified	9
	Nutrition Center	2
	Other Agency	1
	Phone	8
	Phone Book	1
	Presentation	1
	Project Bravo	2
	Referral	12
	Secure Horizon	5
	Seminar	1
	Social Security Office	13
	Sterling Insurance Co.	9

Table 6-1 (Continued)

Number of Applications Completed, by AAA and Outreach Activity
Texas

Rio Grande (con't)	Volar Center	1
	Walk-in	1
	Word of mouth	3
	Parish Halls, Church Facilities	3
	Precinct Offices	1
	Senior Citizen Centers	41
	Total	314
South Texas	Civic Group Sponsored	5
	Colonia Community Centers	23
	Grocery Store	1
	Media	45
	AAA	4
	Family Member	1
	Friend	1
	Home Visit	13
	Hospital	1
	Indigent Office	1
	Not Specified	4
	Referral	23
	Restaurant	1
	Walk in	1
	Walk-in	3
	Precinct Offices	1
	Senior Citizen Centers	16
	Texas Work Force	9
	Total	153
	Total of all AAAs	728

SOURCE: Office of Aging Policy and Information, Texas Department on Aging, 2002.

Slightly more than half of all the applications submitted by the AAAs were eventually certified as eligible by the State (Table 6-2). The numbers ranged from 41 in South Texas to 171 in the Rio Grande. The AAA in the Middle Rio Grande had the highest rate of certification (69.8%), followed by Rio Grande (58.8%). The Lower Rio Grande and South Texas had less than 40% of their submitted applications certified.

Table 6-2

Number of Applications Certified by AAA
Texas

AAA Name	Number of Applications Submitted	Number of Applications Certified	Percent of Submitted Applications Certified
Lower Rio Grande	110	42	38.2
Middle Rio Grande	139	97	69.8
Rio Grande	291	171	58.8
South Texas	124	41	33.1
Total	664	351	52.9

SOURCE: Stockton, J., Bryant, R., Santoyo, L. "Enrollment of Hispanic Dual Eligible on the Texas-Mexico Border," Texas Department of Human Services, Office of Aging Policy and Information, Texas Department on Aging. CMS Contract No. 11-P91162/6-01, December 2001.

Characteristics of beneficiaries who submitted applications are reported in Table 6-3.[1] Across the four AAAs, the average age of an applicant was between 71 and 72 years old. There was a higher percentage of males than females submitting applications in Middle Rio and South Texas, but a higher percentage of females in Lower Rio. The vast majority of all applicants (86% or more) were Hispanic, and the primary language spoken was Spanish (87% overall). The

[1] There is a difference in the "number of applications submitted" in this table and in Tables 6-1 and 6-2 because the AAAs, the Department on Aging and the Department of Human Services tracked applications differently. When the pilot began, the Department of Human Services did not track applications if persons were already receiving services, therefore, there is a discrepancy in the number of applications tracked by Department of Human Services and tracked by Department on Aging. Further, the AAAs tracked all applications regardless of whether the beneficiary was already receiving services. For purposes of Texas' final report, a decision was made to only report on the applications tracked by Department of Human Services.

Table 6-3

Number and Characteristics of Beneficiaries Submitting Applications Through Outreach and Enrollment Activities, as Reported in State Tracking Data

	Texas				
	Rio Grande	Middle Rio	South Texas	Lower Rio	All Regions
Beneficiaries Submitting Applications	296	95	139	122	652
% of Total Applications Submitted	45.4%	14.6%	21.3%	18.7%	100%
Age (mean)	71.6	71.7	71.3	72.2	71.6
Gender	%[1]	%[1]	%[1]	%[1]	%[1]
Male	50	55	56	47	51
Female	50	45	44	53	49
Race					
White	5	14	7	8	7
Black	1	0	0	0	0
Hispanic	94	86	93	92	92
Asian/Pacific Islander	0	0	0	0	0
Marital Status					
Single	4	1	1	0	2
Married	67	65	55	65	63
Divorced	7	3	4	10	6
Separated	3	4	1	1	3
Widowed	19	27	39	24	26
Primary Language					
English	10	20	2	19	11
Spanish	86	80	98	81	87
Both	4	0	0	0	2
Living Arrangements					
Own Home	59	75	57	71	63
Rent House/Apartment	28	12	33	22	26
Live with Someone	4	4	6	0	4
Live in House Provided by Someone	9	9	4	7	7
Pay Rent					
Yes	40	15	29	29	32
No	60	85	71	71	68

[1] Percent distribution within category. Numbers sum to 100 percent within category.

SOURCE: Stockton, J., Bryant, R., Santoyo, L. "Enrollment of Hispanic Dual Eligibles on the Texas-Mexico Border," Texas Department of Human Services, Office of Aging Policy and Information, Texas Department on Aging. CMS Contract No. 11-P91162/6-01, December 2001.

majority of applicants were married, but there were a large number of widowed applicants. For example, in South Texas, 39% of the applicants were widowed. The percentage of applicants who owned their own home varied across regions with 57% owning their own home in South Texas and three-quarters owning their own home in the Middle Rio Grande.

Medicaid Eligibility Data

RTI received data from Texas on dual eligibles for the baseline period (December 1, 1999 through September 30, 2000) and the grant period (October 1, 2000 through September 30, 2001).[2] Texas did not provide Medicaid eligibility data for a full 12-month baseline period because they were not able to recover Medicaid eligibility data prior to December 1999 for the control area. Therefore, we calculate an annualized count of person-years in the baseline period that would be comparable to the grant period by dividing the sum of monthly enrollment in the baseline period by 10, rather than by 12. In addition to the counties in the region covered by the grant, we also received data for a control group consisting of the counties that bordered the demonstration counties and that had similar geography and demographic characteristics: Reeves, Pecos, Terrell, Crockett, Sutton, Kimble, Medina, Frio, Atascosa, McMullen, Duval, Brooks, Kenedy, Loving, Winkler, Ector, Midland, Ward, Crane, Upton, Live Oak, Bee, Jim Wells, and Kleburg. These counties were more sparsely populated compared to those in the demonstration area. However, based on conversations with the staff in Texas, they were determined to be the best choices for a control.

Based on comparison with the control area, it appears that the demonstration had a positive impact on enrollment as enrollment grew by 2.9% more in the demonstration area than would be expected in the absence of the demonstration (Table 6-4). By age group, the largest increase in the demonstration area was among those under the age of 65 (29.6% increase in person-years), whereas there was a 24.5% increase in person-years in the control area. There were also larger increases in enrollment in the 65-74 and 75-84 age groups in the demonstration area compared to the control area. Men experienced larger increases in enrollment in the demonstration area compared to the control area (8.9% versus 7.0%), as did women (7.5% versus 3.9%).

All racial and ethnic groups experienced increases in enrollment. Both Hispanics and Black people realized an increase of 8.6% in the demonstration areas. With the exception of Asian/Pacific Islanders, growth in the demonstration area was greater than in the control area for all racial and ethnic groups. However, although Hispanics were the focus of the grant program, there was little difference (less than 1%) between areas in the growth rate for this population.

Rural demonstration areas had an enrollment increase of 8.5% followed closely by urban areas in the demonstration with an increase of 8.1%. However, compared to the control area, there was relatively greater growth in urban portions of the demonstration area than in rural.

[2] Texas defined its grant period in its Final Report as September 15, 2000 through September 14, 2001.

Table 6-4

Changes in Dual Eligible Enrollment and Beneficiary Characteristics, Demonstration and Control Areas

	TEXAS						
	Baseline Period		Grant Period		% Change[1]		Difference in % Change
	Demonstration Area	Control Area	Demonstration Area	Control Area	Demonstration Area	Control Area	
# of Person-Years	17,384.8	4,736.5	18,801.3	4,982.3	8.1	5.2	2.9
Age	%[2]	%[2]	%[2]	%[2]	%	%	
<65	19.5	22.0	23.3	26.0	29.6	24.5	5.1
65-74	45.8	36.7	45.2	37.0	6.7	6.1	0.6
75-84	24.6	25.6	23.0	24.1	1.1	-0.6	1.7
85+	10.0	15.9	8.4	12.9	-9.5	-14.3	4.8
Gender							
Male	46.3	41.8	46.6	42.5	8.9	7.0	1.8
Female	53.7	58.2	53.4	57.5	7.5	3.9	3.7
Race							
White	10.7	34.7	10.3	33.1	4.0	0.6	3.5
Black	0.6	5.4	0.6	5.4	8.6	5.8	2.8
Hispanic	88.4	59.6	88.8	61.2	8.6	7.9	0.7
Asian/Pacific Islander	0.0	0.0	0.0	0.1	15.4	41.7	-26.3
Native American	0.1	0.2	0.1	0.1	17.8	-33.3	51.1
Other	0.1	0.1	0.1	0.1	66.0	20.2	45.8
Area of Residence							
Urban	83.1	31.0	83.1	30.5	8.1	3.7	4.4
Rural	16.9	69.0	16.9	69.4	8.5	5.9	2.6
Program Eligibility							
MQMB (SSI)	20.1	30.5	19.9	28.4	6.8	-1.9	8.7
QMB	50.1	40.9	48.2	39.1	4.1	0.8	3.3
SLMB	26.0	25.3	27.7	28.4	15.1	18.1	-3.0
MSLMB (Med.Needy)	3.7	3.4	4.2	4.0	21.7	25.4	-3.7

NOTES:

[1] Percent change in person-years of enrollment from baseline to grant period.

[2] Percent distribution within category. Numbers sum to 100 percent within category in each year.

The baseline period includes 10 months of data. Baseline period data were annualized to create comparable counts in the baseline and grant periods.

SOURCE: RTI analysis of Texas Medicaid Eligibility Data, December 1999-September 2001.

The demonstration had a positive impact on enrollment for the SSI and QMB programs. Enrollment in the SSI program increased by 8.7% and enrollment in the QMB program by 3.3% more than would have been expected absent the grant program based on comparison with the control area. However, when compared with the control area, the demonstration area showed a negative effect on enrollment in the SLMB and Medically Needy programs (3.0 and 3.7%, respectively). Percent change by demonstration region is shown in Appendix F, Table F-2. All regions experienced increases in enrollment, with Rio Grande having the largest increase in enrollment (9.3%) followed by Lower Rio Grande, South Texas and the Middle Rio Grande.

Enrollment trends for the baseline and grant periods are shown in Figure 6-1. While the grant counties showed an increasing enrollment trend throughout the demonstration period, the rate of increase was greater during the baseline. The positive trends in the baseline period are likely due to the statewide implementation of the shorter application, self-verification of assets and the mail-in application during this time. Consistent with this, we observe a slight increase in enrollment in the control areas over the baseline period but flat enrollment during the demonstration period. Trendlines by program eligibility and region can be found in Appendix F, Figure F-2 and Figure F-3, respectively.

Cost Data

Program costs and cost-effectiveness are reported in Table 6-5. The State received $182,368 for the grant program and divided it evenly among the four AAAs, although only the Middle Rio Grande used all of its funds. The actual program costs ranged from $38,000 in South Texas to $52,000 in the Middle Rio Grande. Using tracking data to identify beneficiaries enrolled as a result of the grant, it cost, on average, $513.62 to enroll one beneficiary into the MSP. However, the cost ranged greatly across the four AAAs. For example, it cost $300.21 to enroll a dual into the MSP in the Rio Grande region, while it cost $935.31 in the Lower Rio Grande AAA.

The second method of calculating cost-effectiveness is based on Medicaid eligibility data. The results were quite different from those based on tracking data. For example, based on comparison with the control area, we estimated that the Middle Rio Grande had only 12 additional person years of enrollment using eligibility data, whereas tracking data showed 97 new enrollees.[3] At the other end of the spectrum, tracking data showed only 42 new enrollees in the Lower Rio Grande region based on estimates from the eligibility data as compared to 157 additional person years of enrollment. Thus, the estimate of cost effectiveness for individual regions depends on the basis for estimating the number of new enrollees. For the demonstration area as a whole, however, the enrollment estimates based on tracking and eligibility data were not too dissimilar (351 versus 435). On average, using enrollment estimates derived from eligibility data, it cost $414.80 to enroll a beneficiary into the MSP, ranging from $250.89 in the Lower Rio Grande to $4,349.16 in the Middle Rio Grande.

[3] Discrepancies between tracking data and eligibility data can be due to measurement. Tracking data are person-level, whereas eligibility data are person-years. For example, each unique person is counted in tracking data, while one person-year can equal two individuals enrolled for six months each.

Figure 6-1

Texas: Number of Enrollees by Month, Demonstration and Control Areas
(December 1999 - September 2001)

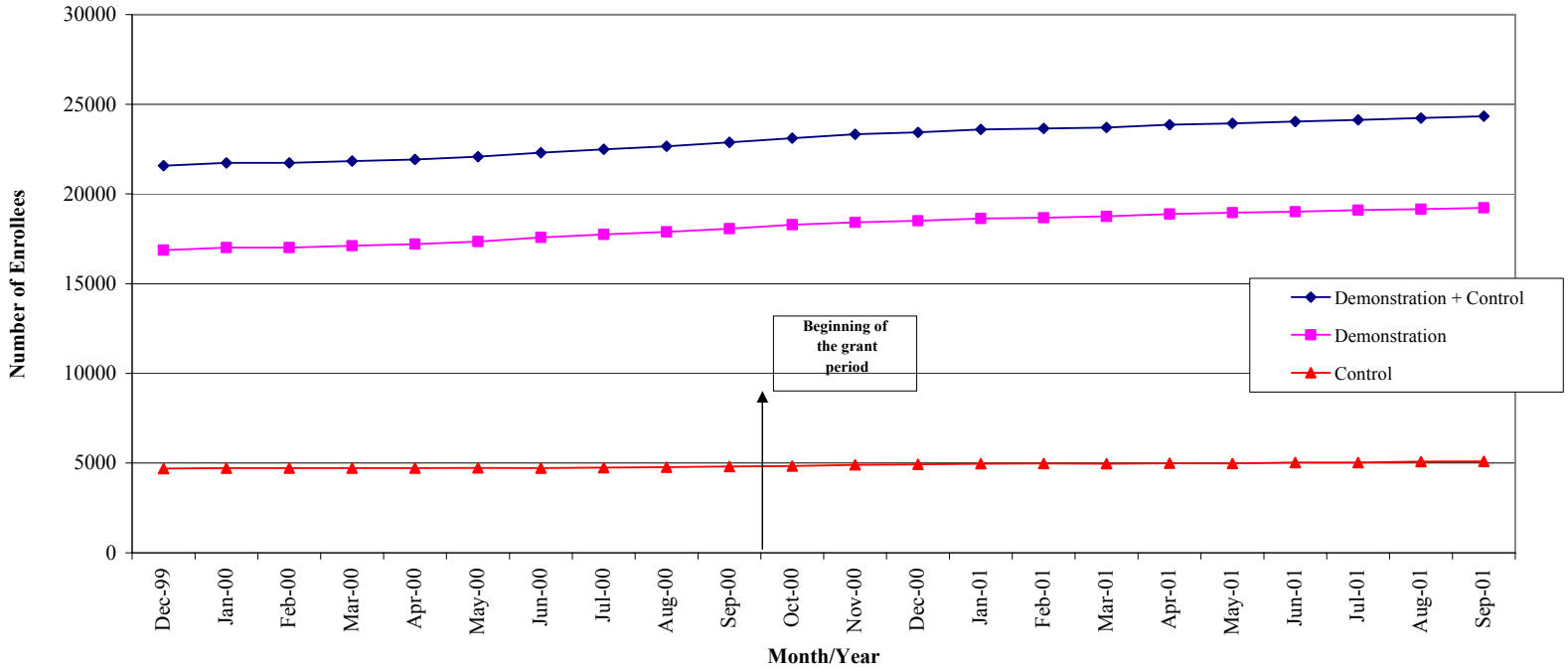


Table 6-5

Texas
Program Costs and Cost-Effectiveness

	Program Costs				Increase in Enrollment		Cost-Effectiveness	
	Federal (budgeted)	Federal (actual)	State[1]	Total	Tracking Data	Eligibility Data[2]	Tracking Data[3]	Eligibility
	$	$	$	$			$	$
Lower Rio	45,592	33,033	6,250	39,283	42	157	935	25
Middle Rio	45,592	45,592	6,250	51,842	97	12	534	4,34
Rio Grande	45,592	45,086	6,250	51,336	171	212	300	24
South Texas	45,592	31,568	6,250	37,818	41	45	922	84
Total	182,368	155,279	25,000	180,279	351	435	514	41

NOTES:

[1]The State reported that they contributed more than $25,000 for the grant in terms of staff time, travel, training, postage and material.

[2]Eligibility data are reported in person-years. The "difference in change" between demonstration and control areas was calculated and multiplied by the number of person-years in the baseline period to calculate the enrollment change based on eligibility data.

[3]The total program cost for each AAA was divided by the total number of certified applicants for that AAA identified in tracking data.

[4]The total program cost for each AAA was divided by the increase in enrollee person-years estimated based on comparison of eligibility data for the demonstration and control areas was calculated for each region. This percentage was then multiplied by the baseline number of person years of enrollment in that region.

SOURCE: Stockton, J., Bryant, R., Santoyo, L. "Enrollment of Hispanic Dual Eligibles on the Texas-Mexico Border," Texas Department of Human Services, Office of Aging Policy and Information, Texas Department on Aging. CMS Contract No. 11-P91162/6-01, December 2001.
RTI analysis of Texas Medicaid Eligibility Data, December 1999-September 2001.

6.4 Conclusions

All partners felt that this initiative was successful. Prior to the grant period, Texas had implemented a number of policy changes that likely had a positive impact on enrollment: a shortened application, self-verification of assets and a mail-in application. This grant allowed the State to focus on the underserved population along the Texas-Mexico border. In addition, lines of communication were opened that were not evident before the grant. The AAAs developed important partners on the State level and on the local level, and the grant increased communications among the AAAs themselves.

The goal of the grant program was to increase enrollment by 4% overall or by 600 beneficiaries (150 in each region) during the grant year. The Medicaid eligibility data indicate that enrollment increased by 8.1% in the demonstration area, while it increased by 5.2% in the control area. Therefore, we can attribute a 2.9% increase in enrollment in the demonstration area to the grant program. By region, increases in enrollment ranged from 6.0% in the Middle Rio Grande to 9.3% in the Rio Grande.

Conducting outreach in rural areas was challenging, as the population was quite dispersed. Much of the success in enrolling beneficiaries into the MSP early in the grant period was concentrated in the region with a large population center (El Paso), which was the focus of initial outreach activities in the region. Outreach specialists found that if they conducted outreach at the same place several times, they would see the same people instead of new faces, evidencing the difficulty in making contact with isolated seniors.

Through the outreach programs, it was discovered that many applicants were already receiving the benefits and did not realize it, which reinforced the advocates' belief that these programs were quite difficult for elders to understand. This was especially true among SLMBs because most have their Social Security checks directly deposited into their bank accounts and do not notice that money has not been deducted for the Medicare Part B premium payment.

There were some issues that were not addressed through the grant. There was miscommunication among the State, the local Department of Human Services' offices and the AAAs about the application process. In particular, there was confusion as to which application forms were to be completed, as well as which documents were to be verified. The outreach specialists completed three forms: the application, an authorization that allows local Department of Human Services' offices to verify bank account information, and a document listing expenses. At the start of the grant, the AAAs were instructed not to verify documentation. Midway through the grant year, the AAAs were told that they were indeed responsible for verification of the documents. This appears to be in conflict with the policy allowing self-verification.

The asset limit remains a barrier for beneficiaries. Many beneficiaries did not qualify for the programs because their resources were too high. They may have had an extra automobile, a life insurance policy with a high cash value or money saved for a "rainy day." In addition, they may have owned plots of land that were difficult to sell because the land was not good for

farming or ranching or because it was difficult to get to. Nevertheless, the land still counted as an asset, which made many ineligible for the MSP.

The AAAs also varied in their ability to track the outcomes of beneficiaries' applications, which some felt limited their ability to assist beneficiaries. This was an issue because the local Department of Human Services offices may have needed additional information to complete the application (the offices are under a timeline to complete the application once the process begins). If AAA staff know about the request for additional information, they can expedite the process by explaining it to the beneficiary, who may not have received notification or may not have understood it. One AAA had the beneficiary complete an authorization form to allow the outreach specialist to learn the outcome of the application. However, unless contacted by the beneficiary, outreach specialists generally did not know whether the application had been approved or required more information.

Interestingly, there was a large discrepancy among the AAAs in the number of applications submitted to the State and those certified by the State. This may be due to a number of reasons, including the experience of staff in educating and assisting beneficiaries in completing applications. There also may have been variation across the regions in the extent to which they "prescreened" applications and only submitted those they believed were eligible.

There were also large differences in the cost-effectiveness of the outreach activities across regions. Based on tracking and eligibility data, the Rio Grande AAA had the most cost-effective outreach activities. The Lower Rio Grande and South Texas were the least cost-effective based on tracking data. However, when cost-effectiveness was calculated with Medicaid eligibility data, Middle Rio AAA had by far the least cost-effective outreach activities.

Overall, the grant had a positive effect on enrollment. It appears that because it was difficult to make direct contact with potential eligibles in all of the regions due to the sparse population, the media was the most effective mechanism for promoting the MSP.

CHAPTER 7
WASHINGTON

7.1 Program Overview and Background

According to interviews conducted during the site visit, the political culture in Washington state requires coalition building as a stepping stone to any policy change. The idea for the coalition to promote the MSP originated at the CMS-sponsored multi-state "Reach Out" conference held in California in January 2000. There, the Washington Medicare Savings Coalition was formed to examine and improve outreach for dual eligibles. It has since expanded to include 31 agencies, only some of which participated in this grant. The agencies that participated in the grant represent the interests of those living in rural areas, Hispanics, Native Americans, the disabled, low-income populations, African-Americans and Asian-Pacific Islanders.

Washington's effort was different from that of other state grant recipients because the goal of the grant was related more to information gathering and analysis rather than just outreach efforts. Washington State emphasized two key components in this grant. The first component was the further development of the Medicare Savings Coalition with a focus on continued outreach to potential eligibles for MSP. The second component was the use of a modified version of an established public health research model known as the Community Identification (CID) process.

The CID is a process for collecting information from various ethnic communities. In the CID model, "key contacts" in the community are identified (in this case, typically people who work with dual eligibles) who in turn identify "gatekeepers" in the community (people who are trusted by the target population, such as grocers or hairdressers). Gatekeepers are interviewed to learn about culturally appropriate outreach strategies to access minority populations. The exchange of this information among coalition members, as well as development of response tailored to individual communities, was to be the key to performing effective statewide outreach to various racial, ethnic and tribal groups. This information was also to be used to tailor the outreach material provided in the CMS "Outreach Kit," as well as to create culturally appropriate training material and a culturally sensitive brochure on the MSP.

In addition, partners were expected to incorporate general outreach and education about the MSP to potential eligibles into their daily activities. Washington did not specify the type of outreach activities to be used by grant participants. Each partner received a lump sum to determine best practices to deliver intensive outreach specifically for the MSP. The outreach efforts differed among the partners, but included:

- work with ethnic community leaders following the CID protocol;
- presentations at senior centers, community groups, food banks, and congregate meal sites;
- articles in senior center newsletters and newspapers;

- direct mailings;
- flyers in laundromats, churches, groceries; and
- brochures for Meals-on-Wheels programs to deliver.

Examples of outreach materials are included in Appendix G.
The partners in this grant, who were all members of the Medicare Savings Coalition, included:

State

- the Washington Department of Social and Human Services Medical Assistance Administration Division of Client Support (DSHS/MAA),

Advocacy Organizations

- the Washington Protection and Advocacy System (WPAS),
- the Senior Information and Assistance Program of King County,
- the Senior Information and Assistance Program of Snohomish County,
- the Senior Rights Assistance Program of King County,
- and the Statewide Health Insurance Benefits Advisors Program (SHIBA),

Local Service Providers

- the Asian Counseling and Referral Service (ACRS),
- the Yakima Neighborhood Health Services, and
- the Puget Sound Neighborhood Health Center.

There were additionally coalition members, such as the Washington Association of Community and Migrant Health Centers, that were not grant partners. Some maintained an active role in the coalition, but declined funding because they lacked staff or were participating in other grants. Map of the state with location of all coalition members is presented in Figure G-1, Appendix G.

DSHS /MAA coordinated the grant activities including Coalition meetings, contracted with outside sources for publication of outreach materials and performed an overall oversight of the grant. Advocacy organizations and service providers participated in outreach activities, performed CID training sessions, and provided application assistance and advice to eligibles.

The project targeted all individuals who were potentially eligible for MSP. However, individual agencies within the coalition targeted specific communities. For example, WPAS, a non-profit federally mandated disability organization, focused on outreach to tribal communities and young disabled Medicare beneficiaries. The SHIBA and Snohomish County Senior Services focused on rural residents. ACRS focused on Asian and Pacific Islander communities. The Senior Rights Assistance Program of King County targeted urban, low-income and African-American beneficiaries. Yakima Neighborhood Health Services targeted their outreach towards low-income populations, Hispanics, and migrant workers.

Washington did not set any goals for the number of new beneficiaries that would be enrolled as a result of its grant. Instead, goals were set for outreach activities. Each participating agency was to conduct at least 15 interviews (10 interviews with key contacts and 5 interviews with gatekeepers) and at least 6 training sessions (4 sessions targeting key contacts and 2 sessions conducted by key contacts with the members of their community). Coalition members were obligated to provide quarterly reports to DSHS/MAA on the number of outreach activities performed and information on applications and their outcomes. Although coalition members were eager to conduct outreach, they were resistant to the burden of any reporting or tracking requirements.

This grant was not the State's first experience with promoting the MSP. According to informants, Washington was involved in a pilot program with the AARP, Medicaid and the Social Security Administration from 1999-2001. The effort involved a direct mailing targeted to low-income seniors.[1]

Washington was interested in this grant as an opportunity to further develop the Medicare Savings Coalition and to serve the State's elderly and disabled. The Coalition had identified numerous barriers to enrollment in the MSP. The major barrier was the lack of awareness among beneficiaries and health care providers that these programs existed. It was recognized that there needed to be a concentrated effort to inform eligible beneficiaries about the MSPs. There was also a general lack of knowledge about Medicare, especially among Native Americans, who believe that the Indian Health Service will take care of all their health needs.

Another identified barrier was a general distrust of the government among some potential eligibles, particularly among immigrants. Medicare, Medicaid and other state and federal assistance programs are new concepts for some immigrants. They do not understand the programs, the process of having to enroll, or how the programs benefit them. In addition, entering a new type of health care delivery system is a challenge. Language and cultural barriers, as well as access and transportation problems in isolated rural areas, compound these issues.

The enrollment process was identified as a barrier for some. Prior to the introduction of a shorter application in 1999, beneficiaries had to complete a long form. In addition, some were resistant to revealing information about their income or assets. Beneficiaries were also reluctant to visit welfare offices to apply due to the associated welfare stigma. The community service offices (CSOs), which are local DSHS offices responsible for accepting applications for the programs, had a poor track record in the eyes of the advocacy groups. There was a general feeling that the CSOs lose applications and that the workers were not properly trained, partly because of the high worker turnover in these positions. Informants at WPAS reported that they found CSO staff gave misinformation about MSP because they were not well informed themselves. Grant participants in King County also reported that in 1999 a total of 8,000 clients were disenrolled due to a statewide computer problem. The mishap was corrected by the state by

[1] This mailing project used a database compiled by SSA. The database included Medicare Part A enrollees who were not enrolled in Medicaid and had a SSDI benefit under $960 for an individual and $1,296 for a couple. Over 127,000 letters were mailed to Washington residents. The outcome was less than a 1% increase in enrollment.

restoring premium payments, reinstating eligibles, and providing applications to persons who initially appeared ineligible. This incident was perceived as another sigh of incompetence by advocates and other Coalition members.

Washington introduced a shortened application shortly before the beginning of the grant, a copy of which is included in Appendix G. Beneficiaries interested in applying for the MSP can apply by mail, by phone or by FAX. At the time of the site visit, Washington was working on creating and implementing an on-line version of the application. Recertification is required annually, using a longer review which is used for multiple programs. The Coalition encouraged the state to pursue a joint use application/recertification form which was being considered at the time of the site visit.

While not in place for MSP, estate recovery remains a barrier for beneficiaries wanting to apply for MSP. Many do not know that it is waived for the MSP in Washington and fear that their homes and savings will be taken away from them. Others also fear the loss of other types of benefits, such as rent subsidies.

Some interviewees believed that many beneficiaries do not feel that the benefits of the MSP are worth the trouble of applying. While beneficiaries would be interested in enrolling in a program that provides assistance with their prescription drug expenses, which can run to hundreds of dollars per month, the opportunity to save $50 per month on the part B premium for some is not a sufficient incentive to enroll in the MSP. Advocates reported that some consumers feel that the QI-2 program is of little value. Washington did not include it as part of the outreach efforts.

7.2 Program Implementation and Operation

Washington proposed to use the CID theoretical framework in order to learn from community leaders about effective outreach methods and to incorporate this knowledge into culturally sensitive outreach activities. The CID process was initially presented in a train-the-trainers orientation for coalition staff and other community members by WPAS, MAA and SHIBA trainers in January 2001. Training sessions introducing MSP to various tribal communities were also conducted. During these presentations trainers identified individuals to work within each community. The goal was to involve community advocates in the outreach efforts and to educate the community about the programs. For example, after attending such a training, one advocate spoke with human resources departments at local businesses to educate them about the MSP so they could inform their employees who were near 65 or who had parents who might be eligible.

However, subsequent steps in the CID process were not well defined and not adequately understood by all participants. According to Coalition members interviewed during the site visit, no feedback mechanism was established to channel information from the CID process back to the DSHS. DSHS felt that the training for the CID process consumed most of the time allocated for the grant. Some Coalition members found the process was difficult to learn and time consuming. In summary, the Coalition was successful in delivering the MSP information to the communities, but not in gathering information about these communities.

The State used the grant money to create a brochure with input from partners in the Coalition and technical support from a marketing company. While the original plan was to use the CID process for developing culturally sensitive content for the new brochure, some Coalition members felt that the brochure was developed before information derived from CID could be collected due to the time constraints of the grant. However, DSHS reported that the feedback from Coalition participants was adequate and that they invited a Coalition sub-group made up of volunteers from the larger group to give feedback to the MAA program manager about size, color, photographs and content throughout the development of the brochure.

7.3 Program Enrollment and Cost Impacts

Tracking Data

Grant participants were required to submit quarterly reports with the following information:

- number of identified community contacts;
- number of trainings, presentations and other activities performed;
- strategies used in outreach;
- and number of applications submitted, denied, and approved by program eligibility category.

According to these reports, 115 applications were approved during the grant period, of which 69 were for the QMB program, 43 for SLMB, and 3 applications for the QI-1 program. However, the State believes that this understates MSP applications associated with the grant.

Medicaid Eligibility Data

Enrollment trends from the baseline to the grant period were analyzed using Medicaid eligibility data from the MMIS for the State of Washington. Since the MSP Coalition included member organizations from all over the state, it was not possible to identify a control group and statewide data are presented. The table presenting statewide enrollment changes (Table 7-1) is organized as follows. The first two columns show the percent distribution within each category (e.g., gender, age, and race) for the baseline and grant periods, respectively. For example, in the baseline period 42.6% of the dual eligibles were under 65 years of age, whereas 45.4 % of dual eligibles fell in this age group during the grant period. The third column shows the percent change in enrollment from the baseline to the grant period for dual eligibles overall and for subcategories of eligibles. For example, in the under 65 age group there were 490,028 person-years of enrollment during the baseline period and 552,441 person-years in the grant period (data not shown). This corresponds to the 13.2 percent increase for this group shown in Table 7-1. It is possible for the percent distribution in a given sub-category to decrease from the baseline to the grant period even though enrollment in that sub-category grew over time in absolute numbers. This could occur if there is proportionately greater growth in other subcategories. Similarly, we could observe an increase in the percent distribution despite a decrease in enrollment if other groups experienced a relatively greater decrease in enrollment.

As shown in Table 7-1, person years of enrollment grew by 6.3% from the baseline period (October 1999 - September 2000) to the grant period (October 2000 - December 2001). The number of unique individuals enrolled in dual eligible programs increased by 8.6% overall. Although we can adjust the number of person-years to control for the difference between baseline
and grant periods by deflating the number of person-years in the grant period by 12/15, this type of adjustment is not appropriate for the count of unique individuals. All enrollment trends below are presented in person-years of enrollment.

The changes in total program enrollment vary by age: while enrollment for those under 65 years of age increased by 13.2%, there was a modest gain in the 65-74 group (6.8%) and a decrease of 9.6% among those 85 and over. The trends in enrollment among males and females are similar but somewhat higher for males. While all ethnic groups demonstrate increases in enrollment, growth was greater for minority populations. This may reflect the impact of outreach efforts targeting these populations under the grant. Enrollment growth was slightly higher in rural areas compared to urban.

Enrollment in each program grew with the exception of the Medically Needy Program which fell by 44.2%. Enrollment grew in all other program eligibility categories. Enrollment in QMB program increased by 12.9% and SLMB enrollment grew by 34.3%. It should be noted that although the percentages for some categories are very large (QDWI and QI), the actual change in enrollment is small because baseline enrollment is low. Figure 7-1 charts monthly enrollment in all dual eligible programs over the baseline period and the grant period. Both the baseline and grant periods demonstrate an upward trend in enrollment, but the increase during the grant period is steeper. While site visit informants reported an erroneous disenrollment of about 8,000 beneficiaries in October and November 2000, no decrease in enrollment of similar magnitude can be seen in the monthly trend lines. Enrollment trends by individual program are presented in Figure G-2, Appendix G. DSHS reported that the program definitions for some MSP categories were changed around October 2001, leading to reallocation of some beneficiaries across programs. The increase in SSI enrollment between October and November of 2001 and the corresponding enrollment decrease in the Medically Needy program can probably be attributed to these changes. This also likely explains the 44.2% decline in the Medically Needy enrollment shown in Table 7-1.

Table 7-1

Statewide Changes in Dual Eligible Enrollment and Beneficiary Characteristics

	Washington		
	Baseline Period	**Grant Period**	**% Change[1]**
# Person-Years	89,971	95,681	6.3
# of Unique Enrollees	108,913	118,255	8.6
Age	%[2]	%[2]	
<65	42.6	45.4	13.2
65-74	23.1	23.2	6.8
75-84	20.8	20.0	2.1
85+	13.5	11.5	-9.6
Gender			
Male	37.4	37.7	7.4
Female	62.6	62.3	5.8
Race			
White	78.1	77.2	5.1
Black	4.4	4.5	7.3
Hispanic	4.2	4.4	12.4
Asian/Pacific Islander	7.3	7.4	8.6
Native American	1.6	1.6	10.3
Other	4.6	5.0	15.8
Area of Residence			
Urban	78.9	78.7	5.7
Rural	21.1	21.3	6.9
Program Eligibility			
SSI	79.7	83.1	11.0
QMB	4.8	5.1	12.9
SLMB	3.3	4.1	34.3
Medically Needy	11.3	6.0	-44.2
QDWI	0.0	0.0	300.0
QI	0.9	1.7	93.6

NOTES:

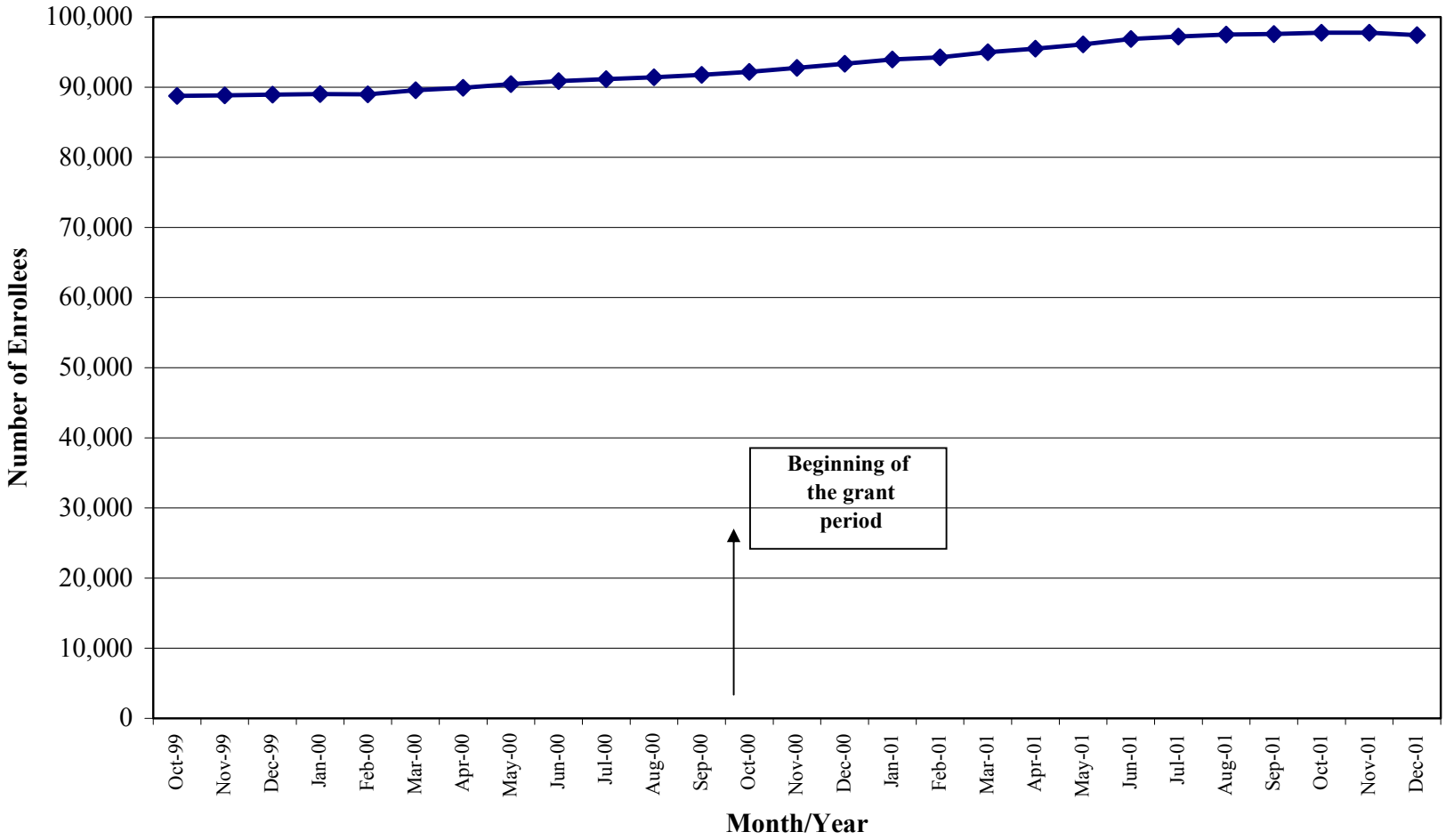
[1] Percent change in person-years of enrollment from baseline to grant period.

[2] Percent distribution with category. Numbers sum to 100 percent within category in each year.

SOURCE: RTI analysis of Washington Medicaid Eligibility Data, October 1999-September 2001.

Figure 7-1

Washington: Number of Enrollees by Month
(October 1999 - December 2001)



Cost Data

Table 7-2 reports the cost of Washington's grant program. The overall cost for the outreach grant was $195,647, which included $160,647 of federal funds and $35,000 in State in-kind matching and other expenditures. Each grant partner from the Coalition received about $20,500. We calculated the cost-effectiveness of Washington's grant program using statewide enrollment growth from the baseline to the grant period. Because the grant was conducted statewide, we were not able to identify a comparison group that could be used to control for enrollment changes that would have been expected in the absence of the grant. Thus, all enrollment growth is attributed to the grant, which is likely to be an overstatement given that there was an upward trend in enrollment prior to the initiation of the grant. Medicaid eligibility data reported by the State to RTI showed that enrollment increased by 5,710 person years between the baseline and grant periods. This translates into a cost of $34 per new enrollee. In its final report on the grant to CMS, Washington reported dual eligible enrollment data from an alternative data source (the Automated Client Eligibility System or ACES system). The state found somewhat higher growth using ACES data – 8,856 new enrollees.[2] Based on ACES data, the cost per new enrollee is $22

Table 7-2

Washington
Program Costs and Cost-Effectiveness

	Program Costs			Increase in Enrollment	Cost-Effectivness
	Federal	State[1]	Total	Eligibility Data [2]	Eligibility Data
	$	$	$		$
Total	160,647	35,000	195,647	5,710	34
Partners	150,272	--	150,272	--	--
Brochure Publication	2,129	--	2,129	--	--
All Other	8,246	--	8,246	--	--

NOTES:
[1]State in-kind match provided in salary and benefits.
[2]Increase in person-years of enrollment from baseline to grant period.

SOURCE:
RTI analysis of Washington Eligibility Data, October 1999-December 2001.

7.4 Conclusion

Washington had a different structure for its grant program compared to other States. The goal was to use an information gathering process that could be the basis for developing culturally

[2] The ACES data differ from Medicaid MMIS data in several respects: (1) the reporting time periods differ and (2) some beneficiaries included on the MMIS data are not included in the ACES data. After taking into account these differences, discrepancies between the MMIS data and the ACES data remained that the state could not account for.

appropriate outreach strategies for increasing enrollment in a variety of racial and ethnic communities across the State. There were three main components of the grant. The CID process was to be used to collect information from various ethnic communities. In addition, partners were given grant monies to increase outreach they conducted for MSP. Finally, the State, together with the partners and through the help of an outside marketing firm, was to develop a brochure to advertise the MSP. This brochure was to include findings from the CID process on how to address the MSP with members of their communities. Neither the process nor the brochure was completed at the time of the site visit (September 2001). A limited edition of the brochure for field testing was produced prior to the end of the grant (December 2001).

It is difficult to identify the impact of the grant on enrollment because only limited tracking data were collected and no control group was available that would allow us to identify enrollment changes that would have been expected in the absence of the grant. Overall, statewide enrollment grew 6% from baseline to the grant period. It is notable that enrollment increased disproportionately in minority populations, which was the focus of the grant.

Many partners believed that coalition building on a grass-roots level was an effective tool for addressing the barriers to enrolling in MSP since it allowed statewide and timely sharing of information. It brought together partners with various expertise and opened up lines of communication that had not existed previously. Coalition members believed that they were able to communicate better with DSHS offices within their region, which led to improved staff training and better responses to applications. Each coalition member established a relationship with the local CSO, which they found effective. Some areas were particularly successful in partnering with their region's CSOs: in Yakima the local office now sends a financial worker to the Yakima Neighborhood Health Center on a regular basis to process applications on-site. Some advocates found the grant gave them the opportunity to establish relationships with local tribes. The Senior Rights Assistance Program of King County was accepted by DSHS as a valid agent and assistant. They helped process MSP applications and followed–up with individual cases, as well as advocated for clients for whom there may have been mistakes in determining eligibility.

Since the State had restrictions on how and where outreach could be conducted, the grant allowed local organizations to develop their own strategies for outreach that would work best with their populations. Two grant participants (Yakima Neighborhood Health Service and Puget Sound Neighborhood Health Center seemed to be effective venues for the outreach due to their direct contact and established trust with the potentially eligible population. An additional advantage was that health care providers at these centers were dedicated to serving the low-income population and knowledgeable about program issues. The clinics stated that outreach for MSP segued nicely with their outreach for other Medicaid programs.

In general, the CID process was reported to be effective in identifying and reaching community leaders and using them as an entrance point for information distribution. However, implementation of this process proved problematic within the short time frame for the grant. Coalition members were excited about the process but felt that they did not receive adequate training to fully understand how it worked. Additionally, the CID process seemed to be misunderstood by many coalition members, who saw it as only a one-way street to inform racial

and ethnic communities about the MSP. A main goal of the CID was to learn how to educate racial and ethnic communities about the MSP and to channel this information back to the coalition to improve and inform future outreach efforts. This seemed to be neglected by many participants, particularly because the grant was not long enough to complete this lengthy process. Also, although the CID process was helpful in reaching community leaders, the information did not necessarily trickle down to other community members. The brochure, which was to be developed during the grant period to replace an existing brochure, did not include findings from the CID process because they were unavailable. However, its design included DSHS, an outside marketing firm, and a sub-group of Coalition members whose feedback was valued and shaped the end result. Some coalition members were disappointed that the State did not wait for their input to inform the brochure. Also, some coalition members felt their review and comment opportunities were offered at a very late stage in the process.

Reporting requirements from the Coalition members were not sufficient for adequately measuring the grant impact. The Coalition members had to submit quarterly narrative reports discussing the types of outreach conducted and the barriers they encountered. However, they felt that these reports were not disseminated so there was no opportunity to draw on the experiences of other members. DSHS, on the other hand, stated that these reports were not disseminated to coalition members because reporting was often late and incomplete.

Although enrollment of Native Americans grew by 10% between the grant and baseline periods, informants felt that reaching the Native American population was a particular challenge, as there are 29 different tribes with varying degrees of infrastructure and civic involvement. Outreach for the MSP was difficult on the Indian reservations, as several tribal authorities declined WPAS offers to conduct presentations on the MSP. Some tribes allowed presentations but set strict limits on the time and format.

There were several problems that were not addressed by the grant. Although lack of MSP knowledge among providers was cited as a barrier, there were no attempts to conduct outreach to health care providers other than those in health clinics. The Medical Identification, a paper ID card that every Medicaid beneficiaries and those MSP enrollees on QMB and SLMB receive every month was also described as problematic. Coalition members suggested it is confusing for elderly people with vision and other impairments to keep track of many monthly cards and to remember which one is the current one. A single yearly card would be more convenient. In addition, the "letter of award", informing beneficiaries of their enrollment, is quite confusing. It lists all the possible programs and only at the end mentions the program that was actually awarded. Most of the beneficiaries and also some advocates have trouble understanding this letter.

While the new application was mostly praised, site visit interviews revealed that many still believe there are problems with the layout of the shortened application, and advocates complained of not being involved enough in its design. The form remains complicated and difficult to fill out. One interviewee noted that, in general, approximately 80% of applications submitted through its organization contain client errors and omissions. Additionally, even after the statewide introduction of the short application form, some DSHS workers were not aware of

it and continued to use the multiple program form which is longer. At the time of the site visit (Sept. 2001), the application was being revised for clarity with feedback from the Coalition.

CHAPTER 8
SUMMARY AND LESSONS LEARNED

8.1 Introduction

This chapter provides a summary of the outcomes of the grant programs and identifies lessons for other States based on the experiences of grant recipients. This chapter begins with a review of findings reported in the preceding six chapters of this report. This review presents key features of the outreach program in each State and our findings on enrollment impacts and the cost effectiveness of each State's activities. We next assess the success of the State efforts relative to the three goals of the grant program identified by CMS. The following section describes barriers to increasing enrollment in the MSP that were not addressed by the grant program. We conclude with recommendations for further research.

RTI's evaluation of the outreach grants drew on three main data sources:

- Medicaid eligibility data;
- tracking data on grant activities collected by the States; and
- case study interviews with State officials and the community partners involved in each of the grants.

Unfortunately, we were limited in our ability to directly assess the effectiveness of the outreach grants. Although we rely primarily on Medicaid enrollment data to measure enrollment impacts of the grant, it is difficult to clearly identify the impact of the grant programs using these data for the reasons discussed below.

In those States where the grant programs operated statewide, we could only compare enrollment during the grant period with enrollment during the baseline period one year prior to the grant. As a result, we are not able to control for changes in enrollment that would have happened in the absence of the grant so that all enrollment changes are attributed to the grant. In those States that did not implement their programs statewide, we identified a control area and used data on enrollment trends in this area to account for the portion of enrollment changes in the demonstration area that was not attributable to the grant. However, in general, we were not able to find ideal controls. For example, several States' grants targeted rural areas of the State and the only remaining areas that could serve as a control were far more urban. In addition, a number of the States that focused on specific regions also had components of their grant program that operated statewide or that might have had spillover effects outside of the demonstration area (for example, changes in the application process or media campaigns). In these cases enrollment changes in the control area partly reflect the impact of the grant program. Furthermore, it is generally not possible to identify the impact of individual components of the State's grant programs using eligibility data.

We planned to supplement our analyses of Medicaid eligibility data with tracking data on the grants collected by the States. These would provide statistics such as the number of applications received and the number of beneficiaries enrolled that could be directly tied to activities under the grant program. Although tracking data such as these will not capture the

impact of generalized outreach activities (e.g., a media campaign), they provide a useful adjunct to the eligibility data. In practice, however, States reported only limited tracking data and, for the most part, these could not be used to identify enrollment impacts.

Given the limitations of the quantitative data available to assess the impact of the outreach grants on enrollment, much of our assessment of the effectiveness of the grant programs relies on information collected during our site visit interviews. These interviews provide valuable information on the perspectives of key informants. However, much of this information is anecdotal and cannot be independently verified. Furthermore, our site visits were conducted while the grants were still underway so that complete results were not yet available.

8.2 Key Features of the Grant Programs

The lead State agency in each program was the Medicaid department, often acting in tandem with a Department of Aging or other department responsible for services to elders. These lead agencies formed partnerships with entities including other State agencies, community organizations, local government, and advocacy groups. Some of these partnerships built on existing relationships, while others were newly developed for this grant. In most instances, the State Medicaid offices partnered with at least one type of aging network to promote the MSP. For example, local AAAs were a partner in every State except Washington. While Washington did not have a direct partnership with AAAs, it partnered with agencies that subcontract to local AAAs to provide insurance information and referral services. Grant funds were then funneled to the local partners to finance outreach activities and development of outreach materials targeted to their community. In Montana and Washington local partners also assisted the State in developing culturally appropriate outreach materials. Four States (Connecticut, Minnesota, Texas, and Washington) helped to establish communication mechanisms between the partners to promote information exchanges on outreach strategies and policy updates.

The States varied in the geographic focus of their grants. The grant programs in two States (Connecticut and Washington) operated statewide. The remaining four grants targeted rural areas of the State. While the grants in Texas, Maryland and Montana exclusively focused on the rural areas of the State, Minnesota also incorporated statewide components.

Some States' grants also targeted specific racial and ethnic populations. Montana's grant focused on Native American people, while the grant in Texas was directed at the Hispanic population. Components of Connecticut's grant activities targeted the Black and Hispanic communities. Among other subpopulations, Washington's grant included the Hispanic, Native American, Black, and Asian-Pacific Islander communities.

There were many commonalities in the barriers to enrollment in the MSP identified in the six States. For example, lack of knowledge about the MSP and welfare stigma were universally identified as barriers. Estate recovery was also widely cited, but it was an especially acute problem in rural areas where even low income populations may own property. In addition, land ownership may make it difficult for residents of rural areas to meet asset tests. Isolation and lack of transportation were also barriers in rural areas. Language and cultural differences were identified as barriers for all ethnic subpopulations, but some groups faced additional unique

barriers. In both Montana and Washington we heard that Native American people are reluctant to enroll in the MSP (and, sometimes, even Medicare) because they believe that the Indian Health Service should provide all of their health care services. In addition, Native American people may find it difficult to provide the required documentation. This was similarly a problem for the Hispanic population living along the Texas-Mexico border. Concerns about jeopardizing the immigration status of other family members was also a barrier for the Hispanic population targeted by Texas.

While each State identified specific underserved populations as the focus for its grant and tailored their efforts to the targeted population, there were many similarities across States in the types of outreach strategies used. Table 8-1 summarizes the approaches used in the grant programs. Every State incorporated presentations and training sessions on the MSP in their grant. These activities targeted potential eligibles, as well as professionals that could be used to inform clients about the MSP and assist them with the application process. The media was also a widely used mechanism for disseminating information. Four of the States placed advertisements or articles in newspapers. Radio and television was used by these States in a variety of ways, including ad campaigns, talk show appearances, and public service announcements. Every State developed printed materials targeted to specific populations. Three States offered "giveaways" that included contact numbers to obtain more information about the MSP. Connecticut used mailings that targeted low-income populations of potential eligibles. Finally, two States conducted home visits or door-to-door outreach. In addition to these outreach activities, two States incorporated a shortened application form as part of its grant activities.

Table 8-1

Outreach Activities by State

State	Presentations/ Trainings	Newspaper Ads/Articles	Radio/ Television	Tailored Printed Materials	"Giveaways"	Targeted Mailings	Home visits/ Door-to-Door
Connecticut	✔			✔		✔	
Maryland	✔	✔	✔	✔	✔		✔
Minnesota	✔	✔	✔	✔	✔		✔
Montana	✔	✔	✔	✔	✔		
Texas	✔	✔	✔	✔			✔
Washington	✔			✔			

8.3 Enrollment Impacts

Enrollment in the MSP increased from the baseline to the grant period in the demonstration areas in all States with the exception of Maryland (Table 8-2). The two States whose grants operated throughout the State showed statewide increases of 5% (Connecticut) and 6% (Washington). Montana and Texas, which had exclusively regional grants, experienced absolute increases in enrollment in their demonstration areas (2% and 8%, respectively). In Maryland and Minnesota most of the grant activities were focused in the demonstration area, but some were also statewide. In Maryland, enrollment declined by 1% in the demonstration area and less than 1% statewide. In Minnesota, enrollment grew by 11% in the demonstration area and 7% statewide.

For those States where the grant did not operate statewide (all States except Connecticut and Washington), we identified a control area in order to account for changes in enrollment that would have occurred in the absence of the grant program. The difference between the enrollment change in the control and demonstration area is attributed to the effects of the grant program. Among the four States where a control group could be defined, only Texas and Minnesota showed an increase in enrollment in the demonstration area compared to the control. Both Maryland and Montana experienced declines.

As noted previously, our ability to assess the impact of the grants on MSP enrollment was limited in several respects. In those States where the grant operated statewide, there was no control group available that would allow us to account for enrollment changes expected in the absence of the demonstration. Even in those States where a control was available, it often was not ideal. For example, in Maryland, Montana and Minnesota, the demonstration covered much of the rural areas of the State so the control counties were more urban. Tracking data, which could have provided an alternative measure of enrollment impacts, was sparsely reported by the grantee States.

Table 8.2

Enrollment Trends by State

STATE	PERCENT CHANGE IN DEMONSTRATION AREA	DIFFERENCE IN PERCENT CHANGE (DEMONSTRATION VS. CONTROL)
Connecticut*	4.7	N/A
Maryland	-1.4	-1.7
Minnesota	11.4	3.5
Montana	2.0	-1.4
Texas	8.1	2.9
Washington*	6.3	N/A

SOURCE: RTI analysis of State Medicaid eligibility data.
*The grants in these States operated statewide. Therefore, the figures represent statewide changes in enrollment because no control could be identified.

8.4 Cost-Effectiveness

Data on the total cost of the grant programs is summarized in Table 8-3. Calculation of the cost-effectiveness of these programs was limited by our ability to accurately estimate their enrollment impacts. We calculate cost-effectiveness only in States where there was a positive change in enrollment attributed to the grant. In States where growth was less than what would have been expected in the absence of the grant (Maryland and Montana), the program was by definition not cost effective. In all States except Texas, we calculated cost effectiveness based on statewide enrollment change. The grants in both Connecticut and Washington operated statewide. Although portions of Minnesota's grant were targeted to specific demonstration counties, some aspects were statewide. In these States where we calculate statewide enrollment changes, all growth in enrollment is attributed to the grant as there is no control that could be used to separate the grant impacts from the growth expected otherwise.

In Connecticut, Minnesota and Washington, the average cost per person-year of enrollment ranged from $34 to $80. In contrast, the average cost per person-year enrolled was $415 in Texas. When we limit the cost-effectiveness calculation for Minnesota's grant program to the demonstration area only, the cost per person-year of enrollment is considerably higher -- $369. There are several reasons why cost-effectiveness is so much lower for the programs that were not statewide. First, as described above, all enrollment growth in States with statewide programs is attributed to the grant. Hence, cost-effectiveness calculations based on these estimates of enrollment growth are generous. Second, the program in Texas and the portion of Minnesota's program that was not statewide focused on very rural areas. Given the dispersion of the population, it is more difficult to devise strategies that can efficiently reach large numbers of people.

Table 8-3
Cost-Effectiveness of State Outreach Programs

STATE	TOTAL COST	INCREASE IN PERSON-YEARS*	COST PER PERSON-YEAR OF ENROLLMENT
Connecticut	$261,202	3,264	$80
Maryland	$221,416	N/A	N/A
Minnesota	$362,329	6,643	$55
Montana	$69,113	N/A	N/A
Texas	$180,279	435	$415
Washington	$195,647	5,710	$34

SOURCE: RTI analysis of Medicaid Eligibility Data and Program Cost Data.
*For all States other than Texas we show the statewide increase in person-years. For Texas, the increase is for the demonstration area only.

8.5 Success in Achieving Goals of the Grant Program

CMS identified three goals for the grant program:

- fostering partnerships;
- increasing enrollment in the MSP and reducing enrollment disparities; and
- developing outreach strategies that could be replicated in other sites.

In the following sections, we assess the success of the grant programs relative to these goals.

8.5.1 Fostering Partnerships

Based on our case study interviews, the establishment of partnerships was widely viewed as one of the most significant results of the outreach grant. All of the States believed that working through entities with established infrastructures and community ties was essential to conducting outreach for the MSP, particularly for hard-to-reach populations. States used the grant to strengthen relationships with existing partners, as well as create new partnerships. Two States entered into new partnerships with FQHCs that were viewed as particularly valuable. While FQHCs are a traditional venue for conducting Medicaid outreach, they more often focus on women and children, rather than dual eligibles. However, FQHCs were viewed as logical partners given their direct contact, as well as existing trust, with low-income and racially and ethnically diverse populations. An additional benefit of involving FQHCs was access to entire families, who became avenues to communicate the MSP information to family members that might be eligible.

States viewed the creation of partnerships through the grant program as a long-term investment. Although the benefits may not have been fully realized during the grant period, participants believed these relationships would be sustained after the end of the grant period and would continue to be productive. In addition, a number of States felt that there would be spillover benefits from the partnerships created for the MSP outreach as these could be a springboard for outreach initiatives targeted to other programs. Overall, the States viewed the collaborative components as central to this initiative.

8.5.2 Increasing Enrollment and Reducing Disparities

Although our ability to identify enrollment impacts of the grants is limited, we generally observed positive enrollment growth in the demonstration areas of the grant States. However, we found a positive effect of the grant in only two of the four states where we could control for enrollment changes expected in the absence of the grant. The growth attributable to the grant was fairly modest in these states, approximately 3%. Furthermore, none of the States achieved the enrollment goal set out in their grant application. It should be noted, however, that some of these goals were quite ambitious (e.g., 14% in Connecticut; 20,000 new enrollees in Minnesota) particularly since many States chose particularly challenging geographic areas and populations to target.

We have little information on the extent to which the grants successfully reduced enrollment disparities in targeted subpopulations. There is, however, evidence for some States that the grants may have been successful in reaching identified subpopulations. For example, compared to White people, enrollment increases were greater for Hispanic people in Connecticut and for all racial minorities in Washington. Although data for Montana did not show that the grant had a positive impact on enrollment overall, we did find an increase in enrollment for Native American people, who were a specific focus of the outreach. On the other hand, in Texas, where the grant targeted the Hispanic community, the increase in enrollment among Hispanic people was no greater in the demonstration counties than in the control counties.

8.5.3 Developing Innovative, Replicable Outreach Strategies

Identifying and enrolling Medicare beneficiaries in the MSP is difficult, as well as time- and resource-intensive. The MSP-eligible are a difficult population to identify. Many are isolated and some have never needed or accessed government assistance programs. For some, government assistance programs are synonymous with welfare and carry a significant stigma. Cultural values of independence, self-reliance and an unwillingness to disclose personal circumstances are particularly strong in many ethnic communities. In addition, the programs remain difficult to describe and understand, especially for elders who are not familiar with the health care delivery system in the United States. The need for education about the MSPs extends beyond potential eligibles to county workers, health care professionals, aging service providers, and volunteers. Contacting and informing potential beneficiaries about the program is particularly challenging in geographically isolated and sparsely populated regions.

The States that participated in the grant program adopted multi-pronged strategies to increasing outreach for the MSP. The effectiveness of different strategies sometimes varied between States and across subpopulations within a State. In this section we summarize findings on the effectiveness of some of the strategies adopted in the grant initiatives. These findings are largely drawn from the case study interviews as we have limited quantitative information on the outcomes of specific activities.

Shortened Applications. Each of the States shortened their application either prior to or during the grant program. While shortened application forms were universally praised in all States, collecting the required documentation and completing the application process remained difficult for some elders.

Assistance with Completing Applications. Several States used outreach workers or volunteers at AAAs to assist beneficiaries in the application process. This assistance was viewed as critical to ensuring that the application process was completed. However, providing this direct assistance is labor intensive and time consuming. Furthermore, its effectiveness can be limited if the person providing this assistance is not able to follow up on the status of the application. Maryland overcame this obstacle by allowing surrogates both to assist in completing the application and to act as representatives that can receive all information regarding the application and re-enrollment.

Door-to-Door Outreach. This strategy can be effective for reaching potential eligibles (e.g., the homebound), who are not likely to attend settings where mass outreach, such as group presentations, is conducted. Some outreach workers found this approach particularly valuable because they could provide assistance with completing the application during the home visit. However, it is an expensive and time-consuming strategy.

Tailored Printed Materials. The States considered it important to develop materials that were culturally sensitive to the specific population being targeted. For example, Texas, Washington, and Connecticut translated their informational brochures into multiple languages. Brochures in Texas and Washington also featured pictures of the specific ethnic groups that were the target of the grant. Montana, which focused on Native Americans, used Native American designs in their promotional materials. In addition, they found it critical that printed materials described the programs in simple terms and used catchy phrases to inform beneficiaries about the benefits (e.g., "Let us Pay for Your Medicare Premiums," "Ask me about affordable Medicare!").

Direct Mailings. Experience in Connecticut indicates that a direct mailing can be an effective strategy if it is well-targeted. Response to the ConnPACE mailing was strong because there is a high likelihood that a ConnPACE recipient is also eligible for the MSP. In contrast, a large percentage of the recipients of the AARP mailing, which was sent to AARP members residing in low-income zip codes, were not in fact eligible for the MSP. Indeed, some recipients of the mailing were offended to have received information targeted toward low-income populations. Although the high degree of overlap between ConnPACE and MSP eligibility made this an effective targeting strategy, it also created confusion among some recipients who were already enrolled in the MSP and thought they needed to re-enroll to retain their benefits. Furthermore, while response to the ConnPACE mailing was strong, it is not known how many of the applicants were already enrolled in the MSP.

Piggybacking on Prescription Drug Programs. Two States piggybacked outreach for the MSP on prescription drug programs. However, the experience in these States varied. Connecticut effectively piggybacked on its prescription drug program by specifically targeting people already enrolled in ConnPACE. The State marketed the MSP as a complement to their existing Medicare and ConnPACE benefits. Minnesota also marketed the MSP as a complement to its prescription drug program, assuming that the popularity of the drug benefit would draw people into the MSP. However this strategy may have been undermined because the MSP is subject to estate recovery, while the prescription drug program is not. Although Minnesota felt this strategy was not successful because they did not achieve their extremely high enrollment goals, the State did not directly assess its effectiveness and its actual impact is unknown.

Use of the Media. Minnesota incorporated a television ad campaign in its outreach program. The State viewed the ads as ineffective because the financing was not sufficient for a saturation campaign. Furthermore, the advertisement was not targeted solely at the MSP. A radio ad campaign was considered only somewhat more effective. Despite the apparent lack of success of the television ad campaign, MSP beneficiaries that were surveyed in Minnesota identified television as the best way to reach them with information on the MSP. Thus, the ineffectiveness of the ad campaign in Minnesota may reflect the problems identified above,

rather than the effectiveness of this strategy generally. The media was one of the most effective outreach vehicles used in Texas. However, in contrast to Minnesota, Texas relied on free appearances on radio and television programs, rather than a paid advertising campaign.

Strategies for Specific Subpopulations. States tended to use two main outreach strategies for rural populations that allowed them to reach large numbers of people in geographically dispersed areas: mass media (e.g., appearances on local television and radio programs, public service announcements, newspaper advertisements and articles) and presentations at community events (e.g., health fairs, powwows, county fairs). Texas and Minnesota also incorporated home visits in their rural outreach efforts. In order to reach Hispanic populations, both Connecticut and Washington worked through community health centers that serve large numbers of potentially eligible people. Both States also used contacts with other family members to reach elders. The Texas grant mainly focused on Hispanic people and a broad range of strategies were used by the different regions participating in the grant. Because of the proximity to Mexico, media outlets in both Texas and Mexico were used. All outreach, both written and verbal, was conducted in Spanish. In addition, it was important for the outreach specialists hired under the Texas grant to be knowledgeable of the local dialect. Both Montana and Washington stressed the importance of working through the tribal community to provide outreach to Native American people. Montana used a variety of approaches emphasizing Native American culture (outreach at powwows, giveaway of a traditional Native American blanket, placemats with a Native American design motif, educational video featuring Native Americans). Connecticut used outreach through places of worship and FQHCs to reach Black people. Washington partnered with organizations that provide comprehensive assistance to the immigrant community in order to gain access to the Asian and Pacific Islander community.

8.6 Enrollment Barriers Not Addressed by the Grants

States identified many barriers to enrollment of duals into the MSP. The barriers can be divided into "policy barriers," (for example, estate recovery, limitations on Medicare cost sharing payments, lack of appeal of the QI-2 program) and "program" barriers (lack of information about the MSP, difficult application processes). While the program barriers can be addressed by improving or targeting outreach, the policy barriers mostly cannot be influenced by these interventions.

States reported that estate recovery remains a major barrier to enrollment, despite efforts to educate beneficiaries that the amounts actually recovered are likely to be small. In the two States that had waived estate recovery (Texas and Washington), informants indicated it remains a barrier because the negative perception and fear of estate recovery is so strong among the elderly.

Asset limits are also barriers. Many interviewees reported that there are large numbers of beneficiaries who meet the income eligibility requirements, but exceed the asset limits. Our analysis of eligibility data for Minnesota provides some support for this contention. In that State we observed a surge in enrollment following liberalization of the asset limit. The asset limit was a particularly acute problem in Texas and Minnesota, where potential beneficiaries may own large tracts of land.

Informants in Connecticut reported that access to services has been restricted by limitations on Medicaid cost sharing reimbursement when the amount reimbursed by Medicare exceeds the Medicaid payment. They reported that, in response, physicians (especially specialists and mental health providers) have limited the number of dual eligible patients they see. These access problems, along with the more limited value of the QMB benefit, were reported to have impeded the ability of advocates to market the programs successfully. All States reported difficulty promoting the QI-2 program given the low value of that benefit.

8.7 Study Limitations

There were a number of limitations on our ability to fully evaluate the impact of these grant programs. Among the problems were: (1) the absence of an adequate control in most States; and (2) the lack of data that directly tracked activities under the grants and their outcomes. If CMS is interested in evaluating the impact of outreach activities such as these in the future, these problems might be addressed if grants are designed with more of an eye to the design of the evaluation. For example, demonstrations could have been designed to explicitly allow for identification of a control site. In addition, as a condition of receiving the grant, more specific requirements for collection and reporting of tracking data could be defined for the States. In particular, tracking data should include information on applications and their outcomes, not simply on outreach activities conducted.

The time period for this grant was likely too short to effectively implement some of the outreach efforts and to measure their impacts. The official start date of the grant was October 1, 2000, but the States did not learn of their award until shortly before this. It took States time to create the formal partnerships required, as well as to hire any personnel needed to implement the grant. Many of the States did not begin their outreach activities until the grant year was well underway. Despite the extension, certain activities that required substantial development did not begin until close to the end of the grant period. Therefore, increases in enrollment that might be attributable to the grant would not be observed until late in the grant period or after it was over. Furthermore, some of these activities were viewed as long-run investments where the returns would not necessarily be felt immediately. The measure of enrollment impacts used in this study (person-years of enrollment) particularly downweights the contribution of new enrollments that occurred late in the grant period. Future studies should follow out program impacts over a longer period of time.

Finally, while the great majority of efforts in this grant were channeled towards outreach and enrollment of new potentially eligible elders into the MSP, some of our case study findings suggest that the complexities of the recertification process remain a barrier to continuous enrollment. Thus, maintaining enrollment is as important as attracting new enrollees if the program is to be successful. This evaluation was not designed to address continuity of enrollment. However, future work under this contract to evaluate the QMB and SLMB programs will examine duration of program enrollment.

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APPENDIX A

PROTOCOL

Evaluation of State Outreach and Enrollment Programs for Dual Eligibles: Protocol

Program Origins

- What were the reasons for pursuing this grant? Of these, what was the single most important reason for pursuing the grant?
- Who was involved in developing the grant proposal?
- What interest groups supported the development of this program?
- What administrative barriers were encountered in developing the outreach initiative?
- What role did county-level government or advisory boards play in the design and implementation?
- What role did advocates and community-based organizations play in the design and implementation?
- What types of outreach activities to identify and enroll duals were already in place before the grant?

Disparities the Program Was Designed to Address

- What special populations or areas are targeted in the outreach strategy?
- How was it decided which populations or areas to target?
- Prior to the initiative, how did beneficiaries learn about the programs?
- Prior to the initiative, how did beneficiaries apply for the programs?
- What were the barriers that beneficiaries faced in applying for the programs?
- How does the initiative address these barriers?

Organization of the Partnership

- Describe the organizational and contractual arrangements between the agencies and interest groups in the partnership.
- How was the partnership formed?

Program Implementation and Operation

- What barriers were encountered in implementing the outreach initiative?
- What problems have been encountered and fixed in the initiative? Are there any you have not been able to fix?
- What do you consider to be effective about the outreach initiative?
- What do you consider to be the least effective or inefficient aspects of the initiative? What changes would you recommend to address these issues?

Enrollment Process

- What are the eligibility requirements for beneficiaries to enroll in the program? Have the requirements changed recently?
- How does the enrollment process function? Has it changed with the outreach initiative?
- What are the procedures to verify eligibility and enrollment of beneficiaries?
- Are there aspects of federal or State regulation that are problematic in enrolling eligible duals? For example, estate recovery requirements?
- Are there aspects of the enrollment process outside the control of the demonstration that have been problematic? For example, the lag time between applying for the program and enrolling in it?
- Has the State identified other needed changes (besides what is in the proposal) to promote QMB and SLMB enrollment? If yes, what are they?
- What is the program doing to assist beneficiaries in maintaining enrollment? How often is recertification required? How does the State educate beneficiaries that recertification is necessary? Are QMBs and SLMBs disenrolled due to lack of recertification? Do you know how many QMBs and SLMBs are disenrolled annually?

Outreach Strategies

- What types of outreach activities have been enacted since the grant was funded? Were these the same ones that were planned or have some been added?
- How was it decided which outreach activities to undertake?

- Are there outreach programs or strategies that the State or community groups are pursuing independent of the grant? If yes, please describe.
- Are they partnerships? Who are the partners?
- How long have the outreach activities been underway? For how long will they continue?
- What are the goals of these outreach activities? Have they been met?
- Are they likely to effect our ability to measure the impact of the grant programs? How?
- Is the State planning any new outreach initiatives? What are they? Did they develop out of experience under the grant program?

Impact of the Program on Targeted Barriers and Subpopulations

- How has the initiative reduced disparities and barriers in applying to and enrolling in the program?
- What are the State's enrollment targets?
- Are they likely to be achieved? Why or why not?
- Are there particular groups that you have been particularly successful at reaching? Are there any groups that you have been less successful at reaching? If yes, why?
- Are there certain geographic areas that you have been successful in reaching? Less successful? If yes, why?
- What types of data are the State collecting the track the impact of the grant program?

Program Successes and Failures

- What parts of the program work well?
- Are there areas of the program that need improvement? What are they?
- What elements of the partnership worked well? Were there parts that did not work well?
- What criteria are being used to determine how effective the outreach has been?
- What is your overall assessment of how well the program is working?

Lessons Learned

- What aspects of the outreach activities would you recommend as models for other States to follow?
- What should be done differently?
- Does the State have plans to continue the outreach initiatives after the grant year has ended? What are they?
- In your opinion, was the partnership successful? Why or why not? Would you recommend that other states form partnerships to address the issue of enrolling dual eligibles? What are the specific aspects of the partnership that you would recommend to other states to follow? To avoid?

Outreach Efforts for Dual Eligibles Generally

- Describe in detail your approach to outreach for dual eligibles (generally, not including the grant). How does this differ, if at all, from general outreach activities for Medicaid and other public assistance programs? Who was involved in developing the approach? Are grass roots organizations involved? What aspects of their approach have been the most successful? The least successful? Has the State modified their approach based on past experience or are they considering doing so?

- Describe in detail the application, eligibility, and enrollment process for the QMB and SLMB programs. Have special provisions been made or are these the same as general procedures for Medicaid? If the same, has any consideration been given to developing special mechanisms? Has the State partnered with other agencies (e.g., the Social Security Administration, county welfare offices) to facilitate referral of potential eligibles?

- How has the State identified populations to target for outreach (generally, not including the grant)?

- What are the State's current outreach priorities for Medicaid? Where does QMB and SLMB outreach fit into these priorities?

- What events and activities other than outreach affect QMB and SLMB penetration rates in their State (e.g., State economic conditions, Medicare HMO activity in the State, adoption of statewide expanded benefits for the elderly such as prescription drug assistance)?

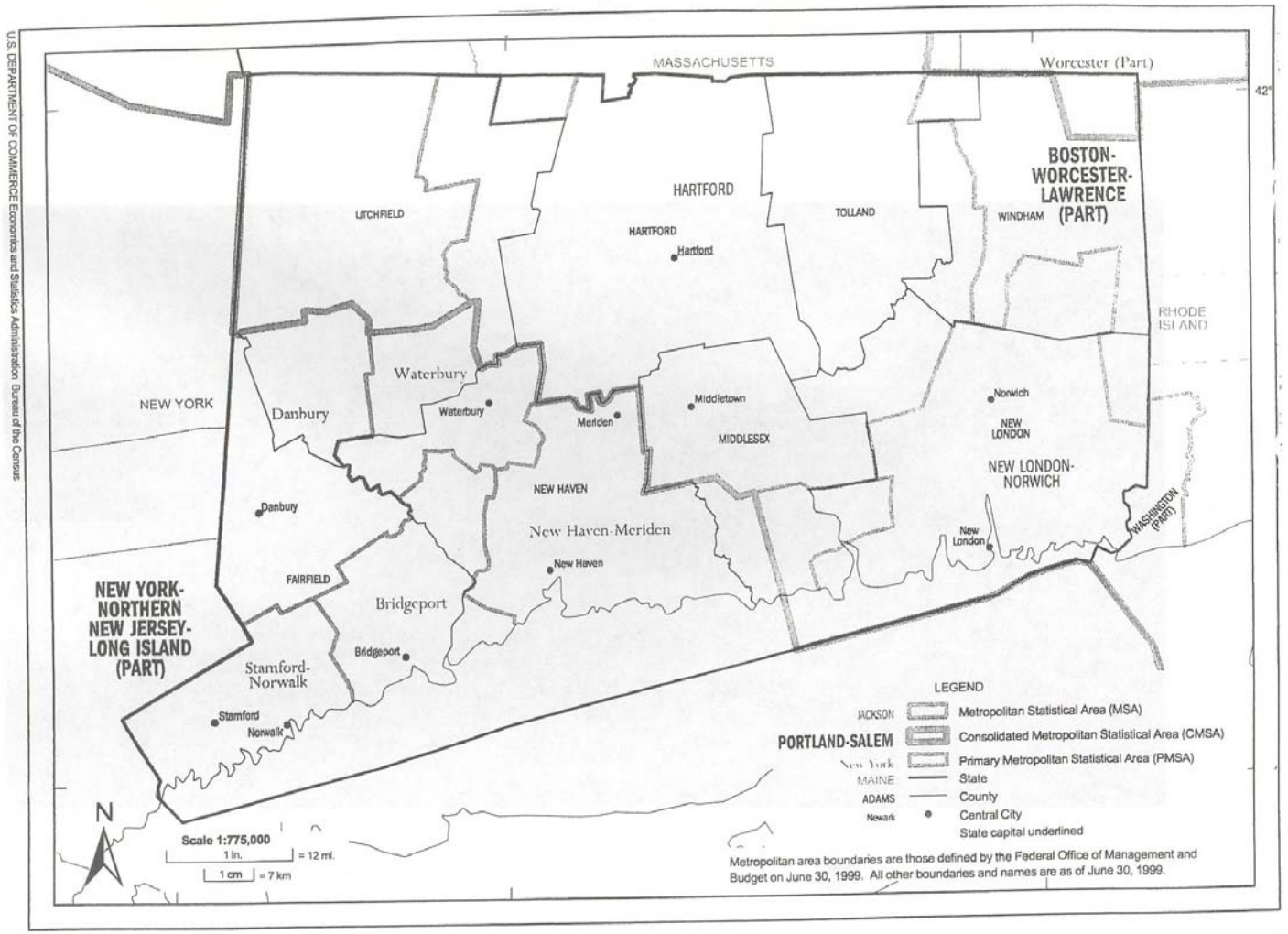
- What could the State do to increase QMB/SLMB enrollment given its current budget? With additional funds?

APPENDIX B

CONNECTICUT

Map of Connecticut

Figure B-1


U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration Bureau of the Census
MASSACHUSETTS
Worcester (Part)
42°
BOSTON-WORCESTER-LAWRENCE (PART)
WINDHAM
HARTFORD
LITCHFIELD
TOLLAND
HARTFORD
Hartford
RHODE ISLAND
NEW YORK
Waterbury
Danbury
Waterbury
Meriden
Middletown
MIDDLESEX
Norwich
NEW LONDON
NEW LONDON-NORWICH
NEW HAVEN
Danbury
New Haven-Meriden
New London
WASHINGTON (PART)
New Haven
FAIRFIELD
Bridgeport
NEW YORK-NORTHERN NEW JERSEY-LONG ISLAND (PART)
Bridgeport
Stamford-Norwalk
Stamford
Norwalk
N
Scale 1:775,000
1 in. = 12 mi.
1 cm = 7 km
LEGEND
JACKSON
Metropolitan Statistical Area (MSA)
PORTLAND-SALEM
Consolidated Metropolitan Statistical Area (CMSA)
New York
Primary Metropolitan Statistical Area (PMSA)
MAINE
State
ADAMS
County
Newark
Central City
State capital underlined
Metropolitan area boundaries are those defined by the Federal Office of Management and Budget on June 30, 1999. All other boundaries and names are as of June 30, 1999.

Connecticut

Enrollment Application and Outreach Materials

W-1429
(Rev. 3/01)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

AARP

MEDICARE SAVINGS PROGRAM APPLICATION
(QMB, SLMB, ALMB, QDWI)

NAME AND ADDRESS

Name *(first)* *(m.i.)* *(last)*

Address *(no.)* *(street)* *(city)* *(zip code)*

Mailing Address *(if different)* *(no.)* *(street)* *(city)* *(zip code)*

Telephone
Your # ( ) _____
Message # ( ) _____

Marital Status
☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Applying For *(check one)*
☐ Self Only ☐ Self and Spouse

Name of Spouse *(first)* *(m.i.)* *(last)*

	Date of Birth	Place of Birth	Race	Social Security Number	Sex *(circle one)*	Maiden Name	Do You Have Medicare? Part A *(circle one)*	Part B *(circle one)*
Self					M F		Y N	Y N
Spouse					M F		Y N	Y N

INCOME

Please list gross income received by you and your spouse. Income includes gross Social Security (including your Medicare Part B premium), SSI, wages, pensions, disability benefits, Worker's Compensation, unemployment compensation, interest, dividends, rental property income, alimony, child support, etc.

SELF			SPOUSE		
Name and Address of Employer, if any:			Name and Address of Employer, if any:		
Name of Pension Company:			Name of Pension Company:		
Source	**How Often Received (Weekly, Monthly or Quarterly)**	**Amount**	**Source**	**How Often Received (Weekly, Monthly or Quarterly)**	**Amount**
Social Security		$	Social Security		$
SSI		$	SSI		$
Wages *(enter gross)*		$	Wages *(enter gross)*		$
Pension		$	Pension		$
Annuity		$	Annuity		$
Other *(describe)*:		$	Other *(describe)*:		$
Other *(describe)*:		$	Other *(describe)*:		$

REAL ESTATE

Address of Property Owned	Owner (self, spouse or joint)	Estimated Value	Amount Owed on Mortgage	Do you live in this property?
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No

INHERITANCE

Do you have an inheritance pending? ☐ Yes ☐ No If Yes, provide details:

PENDING LAW SUIT

Are you suing anyone? ☐ Yes ☐ No If Yes, provide details, including the name of your attorney:

CITIZENSHIP

	U.S. Citizen? *(circle one)*	If no, enter alien status, e.g., permanent resident, refugee, etc.	Alien Registration Number	Country of Origin	Place and Date of Entry into U.S.	Name of Sponsor *(if applicable)*
SELF	Y N					
SPOUSE	Y N					

ASSETS

List all assets owned by you and/or your spouse. Include cash on hand *(money that is not in an account)*, savings and checking accounts, certificates of deposit (C.D.), individual retirement accounts (I.R.A.), vacation and Christmas clubs, revocable and irrevocable burial funds/accounts or any other type of account where your name appears on the account *(even if the money is not yours)*. Include accounts such as those for children or those held in trust for you. List other types of assets such as contents of a safe deposit box, mortgage payable to you, jewelry, furs, and/or paintings held for investment, etc. Under VEHICLES, list any car, truck, boat, camper, recreational vehicle, trailer, motorcycle or other vehicle *(include unregistered vehicles)* that you own or have registered in your name. Under INSURANCE POLICY OR DEATH BENEFIT please be sure to enter the face value (the amount that appears on your policy) and if it is a whole life policy, the cash surrender value.

Asset Type	Owner (self or spouse)	Name of Bank, Fund, etc.	Description	Account or Policy No.	Value
Cash on Hand					$
Bank/Credit Union					$
Bank/Credit Union					$
Annuity					$
Trust					$
Revocable Burial Fund					$
Irrevocable Burial Fund					$
Stocks					$
Bonds					$
Other:					$
Other:					$
Other:					$

VEHICLES

Owner	Make	Model	Year	Value	Amount Owed on Loan
				$	$
				$	$
				$	$

INSURANCE POLICY OR DEATH BENEFIT

First name of Policy Owner	Insurance Co.	Policy No.	Type *(check one)*	Face Value	Cash Value
			☐ Term ☐ Whole Life	$	$
			☐ Term ☐ Whole Life	$	$
			☐ Term ☐ Whole Life	$	$

READ CAREFULLY AND SIGN

I certify that all of the statements made in this application are true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to the penalties for false statements as specified in Connecticut General Statute Sections 53a-157b and 17b-97 and to penalties for larceny as specified in sections 53a-122 and 53a-123. I may also be subject to penalties for perjury under Federal law.

I understand and agree to the following:

- This application constitutes a request for the Medicare Savings Program only (QMB, SLMB, ALMB and/or QDWI).
- If I wish to apply for the Department's other programs, such as cash assistance, Medicaid or Food Stamps, I must complete a separate application form.
- My Social Security number will be used to verify identity and eligibility. My Social Security number may also be used to cross-match information in federal, state and local government files.
- The information on this form is subject to verification by federal, state and local officials. The Department may conduct independent verification of the statements made by me on this application.
- The information available to the Department through the Income and Eligibility Verification System (IEVS) will be requested and used to process my request for assistance. This information will come from the Department of Labor, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. Information received may also be verified directly with other sources such as banks and employers. Results from such investigations may affect my eligibility and level of benefits.
- I agree to cooperate with state and federal personnel in a Quality Control Review.
- I must notify the Department within 10 days of any changes in my income or assets.
- The information given on this form is confidential and will only be used for purposes of program administration.
- I may request a fair hearing in writing if I disagree with an action taken on my case.
- I swear that I am a United States Citizen or, if I am not, that the information I have provided concerning my non-citizen status is true.
- I understand that false or misleading statements on this application violate federal law and may be punishable by a fine up to $25,000 or imprisonment for 5 years, or both.
- I agree to an assignment of pending lawsuit money to the State for medical expenses related to the lawsuit and paid by QMB.
- I understand that by receiving medical assistance, I allow the State to recover the cost of my medical bills which may have been covered by other insurance directly from the insuring company.
- I understand that the State may recover monies from the estates of individuals who received medical assistance benefits and who do not have a living spouse or a surviving child who is under age 21 or blind or disabled.
- I give permission to any health insurer or provider to release information about me to the Department of Social Services. The information requested must concern my claim for medical benefits from the state.
- I will not alter, trade, sell, or use someone else's medical services identification card.
- I understand that my spouse, if I am separated from him or her, may be billed to repay the State for the cost of my medical care.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____

Conservator or other Representative's Signature, if applicable _____ Date _____

This application will be considered without regard to race, color, sex, age, physical or mental disability, religious creed, national origin, sexual orientation, ancestry, language barriers or political beliefs.

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

NORTH CENTRAL AREA AGENCY ON AGING

Medicare is expensive! Medicare Savings Programs can help beneficiaries save $600 per year or more! The Medicare Savings programs provide financial assistance to seniors and other eligible individuals by paying the coinsurance and deductibles not paid by Medicare. Unfortunately, many people are not aware of these programs and their benefits.

Research has confirmed again and again that churches and religious organizations are pivotal influences in the lives of many seniors and are considered a trusted source of information. The CHOICES program at the North Central Area Agency has designed an outreach project that enlists the help of churches and other faith-based organizations in an effort to spread the word about these under-utilized and least understood programs. We hope that you can help us! Affordable health care is one of the primary concerns of seniors and disabled individuals on Medicare. These programs speak directly to this concern.

We have enclosed for your review a brochure outlining the benefits and other useful information. This also provides you with the programs' eligibility standards.

We would welcome the opportunity to speak with you to further discuss the intent of our outreach project or to meet with you personally to discuss in more details the benefits of these programs.

Please call CHOICES at (860) 724-6443 for more information. We would be happy to provide you with more detailed information in the form of a presentation upon request. Feel free to contact us to confirm your receipt of this letter. We would be happy to assist you and answer any questions you may have.

Thank you in advance for your consideration.

Sincerely,

Maureen C. McIntyre
CHOICES Regional Coordinator

Orlando O. Wright
Intern/Medicare Savings Program Outreach Grant

[illegible] HARTFORD SQUARE WEST · SUITE [illegible] · HARTFORD, CT 06106-5128
Telephone 860/724-6443 · 1-800.994-9422 · FAX 860/251-6107

Medicare Health Care Choices:

Continuing education for service providers by
Connecticut Area Agencies on Aging, CHOICES Programs

In order for us to ensure the continuing quality and relevance of our training, please complete the following questionnaire. Please check any of the following as applicable:

- ☐ CHOICES Counselor
- ☐ Housing-Resident Services Coordinator
- ☐ Adult Daycare Centers
- ☐ Municipal Agent
- ☐ Home Health Care Agencies
- ☐ Senior Center Directors
- ☐ Other _____ _____

Please circle the appropriate number.

1. Has the speaker presented the information in a clear and understandable way?
   (1)Yes (2) Quite Well (3) Adequately (4) No
   Comments:_____

2. Did the information provided meet your expectations?
   (1)Yes (2) Almost (3) Somewhat (4) Not Quite (5) No
   Comments:_____

3. Did you find the presentation on Traditional Medicare to be clear and understandable?
   (1)Yes (2) Almost (3) Somewhat (4) Not Quite (5) No
   Comments:_____

4. Did you find the presentation on Medicaid to be clear and understandable?
   (1)Yes (2) Almost (3) Somewhat (4) Not Quite (5) No
   Comments:_____

5. Did you find the presentation on Financial Assistance Programs for Low-Income Medicare Beneficiaries such as QMB and SLMB effective in providing information?
   (1)Yes (2) Almost (3) Somewhat Effective (4) Not Effective
   Comments:_____

6. How useful did you find the materials that were provided (handouts)?
   (1)Very useful (2) (3) Useful (4) Not Useful
   Comments:_____

7. Overall, can you make use of the information that was presented?
   (1)Yes (2) No
   Comments:_____

8. What would you like to hear less about in the future for an update training?
   Comments:_____

9. I would attend future sessions on the following topics:

- ☐ Grievances and Appeals
- ☐ Health care fraud/Waste and abuse
- ☐ Medicare Supplemental Insurance
- ☐ Support Systems(Medigap, employer, and Support programs)
- ☐ Medcaid
- ☐ Long-Term-Care Insurance
- ☐ Home health care issues
- ☐ Part B coverage (home health, durab medical equipment , ambulance)
- ☐ Medicare preventive services
- ☐ Others:

This training was funded in part, through a grant received from the federal Administration on Aging

MEDICARE IS EXPENSIVE
... Medicare Savings Programs Can Help

A Choice of 5 Statewide Locations:

- **Monday, March 5, 2001**
  Southwestern CT Area Agency on Aging, Bridgeport
- **Tuesday, March 6, 2001**
  South Central CT Agency on Aging, West Haven
- **Thursday, March 22, 2001**
  Community Renewal Team, Hartford
- **Tuesday, March 27, 2001**
  Rose City Senior Center, Norwich
- **Wednesday, March 28, 2001**
  Western CT Area on Aging, Waterbury

AGENDA

9:30 – 10:00	Sign-In and Breakfast
10:00 – 12:30	Medicare and Medicaid Overview, Medicare Savings Programs: Policies and Procedures
12:30 – 1:30	Lunch (provided)
1:30 – 3:00	Identifying Under-Served Populations and Developing Effective Outreach Strategies

Breakfast and lunch will be provided by the Outreach Network, a program of the Connecticut Primary Care Association

REGISTRATION FORM
(please print)

Name: _____

Title: _____

Organization: _____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

E-mail: _____

I WILL BE ATTENDING: (check one)

- ☐ March 5th, Bridgeport
- ☐ March 6th, West Haven
- ☐ March 22nd, Hartford
- ☐ March 27th, Norwich
- ☐ March 28th, Waterbury

REGISTER BY FAX, E-MAIL, OR PHONE TO:

Christine Adamian
Connecticut Primary Care Association

E-mail: cadamian@ctpca.org
Phone: (860) 727-0004 / **Fax:** (860) 727-8550

PLEASE NOTE:

- *Pre-registration is required.*
- *Registration confirmation and directions will be sent to each participant.*

TRAINING HIGHLIGHTS

Designed for the busy professional, this intensive one-day workshop will educate local health and community services professionals on the Medicare Savings programs (also known as QMB, SLMB & QI). Eligibility and enrollment processes will be discussed as well as the scope and function of the programs. The afternoon session, aimed at maximizing beneficiary enrollment, will utilize an interactive approach toward identifying target populations and developing effective outreach strategies.

TRAINERS / FACILITATORS

REPRESENTATIVES FROM:

- THE CENTER FOR MEDICARE ADVOCACY, INC.
- THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
- AREA AGENCIES ON AGING – "CHOICES" PROGRAMS

WHO SHOULD ATTEND:

Public Benefit Workers

Community Outreach Workers

Social Workers

Hispanic Outreach Workers

Elderly Network Professionals

Resident Services Coordinators

FIND OUT THE ANSWERS TO THESE QUESTIONS:

- *Who is Eligible for Medicare Savings Programs?*
- *What do these programs offer?*
- *What does the Medicare Beneficiary need to do?*
- *How do professionals reach potential beneficiaries?*

Connecticut Primary Care Association
90 Brainard Road, Suite 101
Hartford, CT 06114

The Outreach Network

presents

MEDICARE IS EXPENSIVE ..

Medicare Savings Programs Can Help!

Learn how you can help people with Medicare save $600 a year or more.

9:30 a.m. – 3:00 p.m.

5 LOCATIONS:

March 5, 2001, Bridgeport
March 6, 2001, West Haven
March 22, 2001, Hartford
March 27, 2001, Norwich
March 28, 2001, Waterbury

Sponsors

Connecticut Primary Care Association

State of Connecticut Direction for Aging Issues CHOICES Area Agencies on Aging

THE CENTER FOR MEDICARE ADVOCACY, INC.

1. How can I receive an extra $50 each month?

If you have Medicare, you pay a $50 premium each month for your Part B Medicare coverage. (Part B pays for doctor bills, lab tests, x-rays, etc.)

You may not realize you are paying this premium because it is automatically deducted from your Social Security check each month.

If you qualify for three of the four Medicare Savings Programs described in this brochure, the State of Connecticut will pay the Part B premium for you. **Your Social Security check will then increase by $50 each month!**

2. Are there other benefits?

Yes! If you qualify for QMB, we will pay your Medicare coinsurance (co-payments) and deductibles, up to the Medicaid rate. In some cases, we may also pay your Medicare Part A premium. (See question 11.) These benefits could save you hundreds or even thousands of dollars each year!

To qualify, you must be eligible for Medicare Part A. In addition, your income and assets must be within program limits. Please see the table on the back for a description of benefits at each income level.

3. Is there a cost to me?

No! There is no charge to you for any of the benefits under these programs.

4. What is the asset limit?

For QMB and SLMB, countable assets may not be more than $4,000 for one person or $6,000 for a married couple. However, effective April 1, 2001, there is **no asset limit** for the ALMB programs!

5. What are assets?

Assets include bank accounts, stocks, bonds, annuities, trusts, non-home property, some types of life insurance policies, etc. However, not all assets are counted in determining your eligibility. Some assets, such as term life insurance policies and irrevocable burial funds, are totally excluded.

6. What if I own a home or a car?

The home you live in, one automobile, home furnishings, personal effects and burial plots are not counted toward the asset limit. We do <u>not</u> place a lien on the home you live in, but we do recover benefits paid on your behalf from your estate.

7. Is there an income limit?

Yes. The level of help that you receive depends on your countable income. The table on the back shows the benefits available at different income levels.

8. What is income?

Income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends. However, not all income is counted.

We allow certain deductions in calculating your countable income amount. For example, we do not count the first $183 of unearned income (such as Social Security or pension). That is a $366 exemption for a married couple. We also disregard a portion of any earned income you may have from employment.

9. How do I apply?

Contact the Department of Social Services office nearest you. Or telephone a CHOICES health insurance counselor at your Area Agency on Aging. They will answer your questions send you our simple four-page application and a postage paid return envelope.

To reach a CHOICES counselor, call
1-800-994-9422

10. Will I need to provide any documents?

You do not need to provide any documents other than your completed application. The Department will independently verify the information you provide on the application form.

We will also verify that you either have or are eligible for **Medicare Part A coverage.** (Part A pays for hospital care and other inpatient services.) In most cases, the premium for Part A is paid for by the federal government, not by the Medicare beneficiary.

11. What if I don't have Part A?

Some people choose not to take Part A when they become eligible for Medicare. They can change their minds later, but in this case, the Medicare beneficiary pays the Part A premium rather than the federal government.

If you were eligible for Part A but elected not to take it at enrollment, **the State of Connecticut will pay the Part A premium for you under the QMB program.**

If you are not sure whether you have Part A, check your Medicare card or call the Social Security Administration at 1-800-772-1213.

Generally, if your monthly income Is at or below these levels...	You may qualify for...
$ 899.00 single $ 1,334.00 couple	**QMB** - This program is similar to a "Medigap" policy. It pays your Part B premium[1] and all Medicare deductibles[2] and co-insurance.[3] [1] Part B = $50 in 2001. (This amount increases every year.) [2] The 2001 hospital deductible is $792 (This amount increases every year.) [3] Co-insurance is the portion of Medicare approved services that you are responsible to pay. This is usually 20% of the approved Medicare charge, up to the Medicaid approved rate.
$ 1,042.20 single $ 1,527.60 couple	**SLMB** - This program pays for your Part B premium only ($50/month).
$ 1,149.60 single $ 1,672.80 couple	**ALMB (group 1)*** - This program for your Part B premium only ($50/mo.), subject to available program funding.
$ 1,436.00 single $ 2,060.00 couple	**ALMB (group 2)*** - This program only pays for a small portion of your Part B premium ($3.09 per month in 2001); however, this amount increases every year. * This program is subject to available funding.

These income limits became effective on April 1, 2001.
They generally increase on April 1 of every year.

COULD YOU USE UP TO $50 * EXTRA EVERY MONTH?

****

If you already have this program, or if you have an application pending, pass this mailing along to a friend!!!

****

If you are eligible for Medicare Part A, you may qualify for one of the State of Connecticut's

MEDICARE SAVINGS PROGRAMS

These programs (QMB, SLMB and ALMB) help to pay for your Medicare premiums and, in some cases, for your Medicare coinsurance and deductibles.

Look inside to see if you qualify...

Deaf and hearing-impaired persons may use a TDD/TTY by calling 1-800-842-4624. Questions, concerns, complaints or requests for information in an alternative format may be directed to 1-860-424-5250.

This is the amount of Medicare's Part B monthly premium starting January 1, 2001.

DSS Publication No. 00-4 (special rev. 5/01)

Connecticut

Tables and Figures

Table B-1

Connecticut: Percent Change in Enrollment Between Baseline and Grant Periods by Region

	Central	Eastern	North Central	Northwest	South Central	Southwest
	%	%	%	%	%	%
# of Person-Years	22.4	4.6	4.3	5.6	5.1	3.9
Age						
<65	4.2	10.6	10.1	9.5	10.8	10.6
65-74	130.5	4.1	6.3	9.4	8.0	8.0
75-84	11.8	5.8	3.1	7.3	5.8	2.2
85+	15.7	-9.7	-8.6	-8.2	-8.6	-9.4
Gender						
Male	21.8	4.8	4.0	-14.6	4.7	4.0
Female	22.7	4.5	4.4	6.0	5.3	3.9
Race						
White	17.9	4.3	4.1	5.1	5.2	3.1
Black	50.0	5.9	3.9	5.7	3.3	4.4
Hispanic	0.0	7.1	5.3	9.8	5.9	7.0
Asian/Pacific Islander	71.4	8.1	8.7	8.6	12.9	1.4
Native American	0.0	19.2	4.8	-0.5	7.1	-5.2
Program Eligibility						
SSI/ LTC/ HCBS[1]	1.5	-1.2	-0.9	0.0	-0.7	-1.0
QMB	0.3	17.2	18.5	27.5	27.8	33.6
SLMB	133.0	26.4	42.9	45.3	50.0	41.4
Medically Needy	0.0	1.6	4.2	-5.5	-2.0	-0.8
QI	258.0	181.0	157.0	192.0	224.0	199.0
Other	-16.7	138.0	121.0	109.0	131.0	121.0

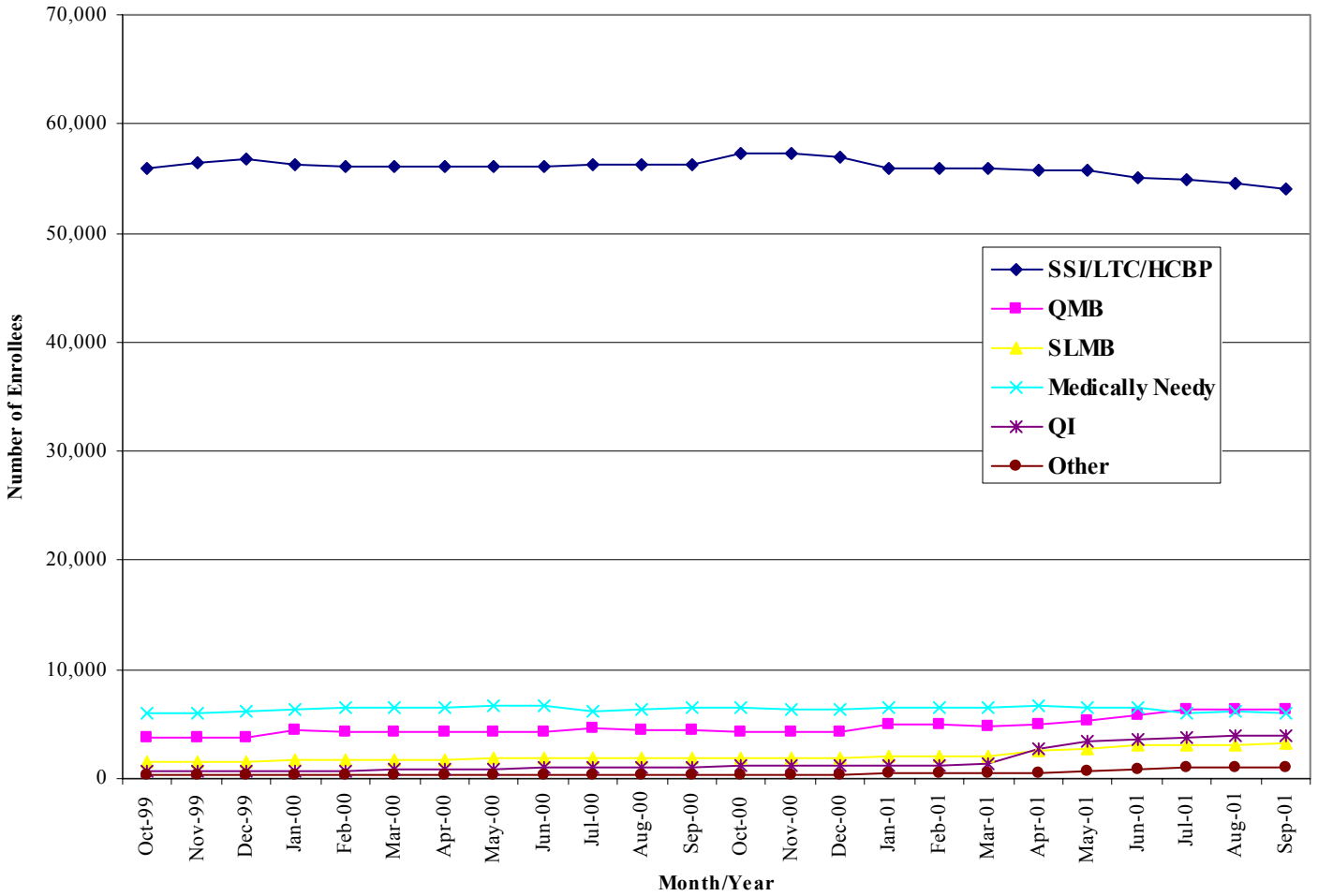
NOTE:

[1] SSI- Supplemental Security Income; LTC-Long Term Care (institutionalized); HCBS- Home and Community Based Services.

SOURCE: HER analysis of Connecticut Medicaid Eligibility Data, October 1999 - September 2001

Figure B-2

Connecticut: Number of Enrollees by Program Eligibility and Month (October 1999 - September 2001)



APPENDIX C

MARYLAND

Map of Maryland

Figure C-1

Target Counties

Western Maryland	Upper Eastern Shore
Garrett County	Cecil County
Allegany County	Talbot County
Washington County	Caroline County
Frederick County	Kent County
	Queen Anne's County

Southern Maryland	Lower Eastern Shore
Charles County	Dorchester
Calvert County	Wicomico
St. Mary's County	Worcester
	Somerset

Maryland

Enrollment Application and Outreach Materials

Application for Medicare Beneficiaries

Please print

Section 1. Information about you.

Your Name: _____
First *Middle* *Last*

Address: _____
Street Address *Apt. No.*

_____
City *State* *Zip code*

Telephone Number: (_____)_____-_____

Date of birth: _____ Sex: ❑ Male ❑ Female Race: _____

Your Social Security Number: _____-_____-_____

Medicare Number: _____-_____-_____

Marital Status: ❑ Never married ❑ Married and living with spouse
❑ Divorced ❑ Separated ❑ Widowed

Are you a citizen of the U.S.? ❑ Yes ❑ No
If not a citizen, date of arrival in the U.S.: _____ INS ID Number: _____

Section 2. Information about your spouse.

If you are living with your spouse, please complete the following information about him or her.

Name: _____
First *Middle* *Last*

Date of Birth: _____ Race: _____

Social Security Number: _____-_____-_____

Medicare Number: _____-_____-_____

Is this person a citizen of the U.S.? ❑ Yes ❑ No
If not a citizen, date of arrival in U.S.: _____ INS ID Number _____

Section 3. Income.

Type of Income	Amount	How Often (Monthly, weekly, etc)	Received by: Applicant	Spouse
Social Security	$		❑	❑
Social Security	$		❑	❑
V.A. Benefits	$		❑	❑
Rail Road Retirement	$		❑	❑
Civil Service Annuity	$		❑	❑
Pension	$		❑	❑
Rental Income	$		❑	❑
Mortgage Income	$		❑	❑
Interest	$		❑	❑
Earnings	$		❑	❑
Other:	$		❑	❑
	$		❑	❑
	$		❑	❑

Section 4. Assets.

Type	Name of bank or institution, or location	Owner: Applicant	Spouse	Value
Savings		❑	❑	$
Checking		❑	❑	$
Stocks		❑	❑	$
Bonds		❑	❑	$
Real Estate		❑	❑	$
Burial Fund		❑	❑	$
Other:		❑	❑	$
		❑	❑	$

Section 5. Vehicles. List any cars, trucks, boats or other vehicles that you own.

Type of vehicle	Make	Year	Model	Do you use this vehicle for transportation to: Medical care?	Employment?
				❑Yes ❑No	❑Yes ❑No
				❑Yes ❑No	❑Yes ❑No

Section 6. Life insurance.

Insured Person	Insurance Company	Policy Number	Face Value	Cash Value
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

Section 7. Health Insurance.

Insured Person	Insurance Company	Policy Number

Section 8. Authorized Representative. This section is optional. Complete it only if you want someone else to handle your medical assistance eligibility for you.

If you would like another person, such as a relative, friend or attorney to represent you in your applications for benefits, to receive copies of all letters about your eligibility, and to speak to the department about your case, please fill in the following:

Name of representative:_____

Address of representative:_____

_____

Daytime telephone:(____)_____-_____ Evening telephone:(____)_____-_____

Representative's relationship to you:_____

I would like the representative above to: (*check all that apply*)

- ❑ Receive copies of all letters about my eligibility, and to discuss my eligibility with the Department of Social Services and the Department of Health and Mental Hygiene.
- ❑ Receive and complete my annual applications for me.
- ❑ Receive my identification card for me.

I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate with the State as required. Everything in this application is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant or Representative **Date**

_____ _____ _____

Signature of Interviewer Telephone Number Date

Rights and Responsibilities

I agree to the release of personal and financial information from my application to agencies determining eligibility for the Medical Assistance Program so that they can evaluate it and determine eligibility. I understand that I may be asked to provide additional information. I have the right to appeal any decision made concerning my eligibility. Officials of the Department of Human Resources and the Department of Health and Mental Hygiene may verify all information on this form. I understand that I must tell the agency that determines my eligibility about any changes in the information reported on my application. By signing the application form, I certify under penalty of perjury that everything on the form is the truth as best I know it.

I certify that those listed on this application form are U.S. citizens or lawfully admitted aliens. Proof of lawful immigration status may be required.

All information and documentation gathered for determining eligibility is confidential. Disclosure of information concerning eligibility to anyone not authorized to receive it is a violation of State and Federal laws.

I understand that I am required by law to assign to the State all third party payments (hospital and medical benefits) and to cooperate with the State in securing such payments. I also understand that the State may recover from the estate of any person over 55 years old an amount not to exceed the amount of benefits paid out on behalf of that person. There will be no recovery from the estate of a deceased individual with a surviving spouse.

I understand that the Program will use social security numbers to verify information such as income and insurance and to help maintain files regarding eligibility and payments. The information may be matched with records in other agencies, such as the Social Security Administration or the Internal Revenue Service.

MB Outreach Interview
Narration and Documentation

Interviewer Name_____ Title_____
Agency_____ Telephone (____)____-____
Address_____ Date of Interview:_____
_____

Applicant 1.

Name_____ D.O.B._____

SSN____-____-____ Medicare No.____-____-____,____

Applicant 2.

Name_____ D.O.B._____

SSN____-____-____ Medicare No.____-____-____,____

□ Withdraw Application Signature_____ Date _____

Narration

Copy: QMB Outreach Coordinator, DHMH

State of Maryland
Department of Health and Mental Hygiene

Application for Medicare Beneficiaries Only

This application form may be used only by persons who receive Medicare benefits. This application may be used by single adults or married couples, but may not be used by families which include children under 21 years old. By filing this application form you are requesting benefits through the Maryland Medical Assistance Program. The benefits you are requesting with this form are limited to the following:

- Payment of monthly Medicare premiums
- Payment of Medicare co-payments
- Payment of Medicare deductibles
- Partial reimbursement of Medicare premiums

You may be eligible for full payment of your premiums, co-pays and deductibles as a Qualified Medicare Beneficiary (QMB), or you may be eligible for payment of your premium only as a Specified Low Income Medicare Beneficiary (SLMB, SLMB 2 or QI 1), or you may be eligible only for partial reimbursement of your premiums (SLMB 3 or QI 2).

Eligibility for these benefits is based on the amount of your monthly income from Social Security, Veteran's benefits, Civil Service Annuities, pensions and any other income or earnings. Eligibility also depends on the amount of money you have in the bank, as well as other assets such as stocks, bonds, real estate, or other investments. You will need to show proof of the amount of your income and the value of your assets. Other factors, such as citizenship and address may also affect your eligibility.

Please answer all of the questions on this form as best you can. You will need to show the interviewer proof of all of the information on the form. If you do not have the proof when you fill out the form, you may mail the information in at a later time. The interviewer will give you instructions on where to mail the information.

Rights and Responsibilities

I agree to the release of personal and financial information from my application to agencies determining eligibility for the Medical Assistance Program so that they can evaluate it and determine eligibility. I understand that I may be asked to provide additional information. I have the right to appeal any decision made concerning my eligibility. Officials of the Department of Human Resources and the Department of Health and Mental Hygiene may verify all information on this form. I understand that I must tell the agency that determines my eligibility about any changes in the information reported on my application. By signing the application form, I certify under penalty of perjury that everything on the form is the truth as best I know it.

I certify that those listed on this application form are U.S. citizens or lawfully admitted aliens. Proof of lawful immigration status may be required.

All information and documentation gathered for determining eligibility is confidential. Disclosure of information concerning eligibility to anyone not authorized to receive it is a violation of State and Federal laws.

I understand that I am required by law to assign to the State all third party payments (hospital and medical benefits) and to cooperate with the State in securing such payments. I also understand that the State may recover from the estate of any person over 55 years old an amount not to exceed the amount of benefits paid out on behalf of that person. There will be no recovery from the estate of a deceased individual with a surviving spouse.

I understand that the Program will use social security numbers to verify information such as income and insurance and to help maintain files regarding eligibility and payments. The information may be matched with records in other agencies, such as the Social Security Administration or the Internal Revenue Service.

About my application

I applied for benefits as a Medicare Beneficiary. I may be eligible as a Qualified Medicare Beneficiary (QMB), Specified Low Income Beneficiary (SLMB), or as a Qualifiying Individual (QI). I understand that if I am eligible for any of these benefits they will not cover all of my medical expenses, but may help me to pay my Medicare premiums, deductibles and co-payments. I understand that if I need help with other medical expenses I must file a separate application at the Local Department of Social Services.

I was interviewed on _____

I was interviewed by_____
Name

_____
Title

_____
Agency

My interviewer's telephone number is:
(_____)_____-_____

I need to send in the following items:

_____

_____

I need to mail these by:_____

These must be mailed to:

_____

_____

_____

My application is being processed by:

_____

_____

_____

Maryland

Tables and Figures

Table C-1

Maryland: Percent Change in Person-Years of Enrollment Between Baseline and Grant Periods Region in the Demonstration Area

	Western Maryland	Southern Maryland	Upper Eastern Shore	Lower Eastern Shore
	%	%	%	%
# of Person-Years	-1.5	-0.6	-1.5	-1.8
Age				
<65	8.8	10.2	11.9	9.7
65-74	-3.0	3.4	-2.0	0.3
75-84	-6.2	-6.8	-7.4	-7.8
85+	-16.9	-22.9	-23.2	-20.8
Gender				
Male	-1.5	-2.1	1.0	-1.3
Female	-1.5	0.2	-2.8	-2.1
Race				
White	-1.5	-1.6	-1.6	-2.5
Black	-1.9	0.8	-2.5	-1.6
Hispanic	20.8	13.8	17.4	11.8
Asian/Pacific Islander	8.7	4.2	30.9	-8.5
Native American	28.9	-0.5	9.1	57.8
Unknown	-7.8	-6.8	11.5	4.3
Area of Residence				
Urban	-1.6	-0.9	-0.8	N/A
Rural	-0.6	-0.1	-2.1	-1.8
Program Eligibility				
SSI	9.8	7.9	7.7	6.1
QMB	-14.5	-14.1	-15.5	-15.5
SLMB	-16.8	-22.5	-27.4	-18.3
Medically Needy	-33.6	-37.3	-39.6	-32.8
QI-1	0.0	-6.7	-31.2	-28.8

SOURCE: HER Analysis of Maryland Medicaid Eligiblity Data, October 1999 - December 2001.

Figure C-2

Maryland: Number of Enrollees by Progam Elligibility and Month
(October 1999-December 2001)

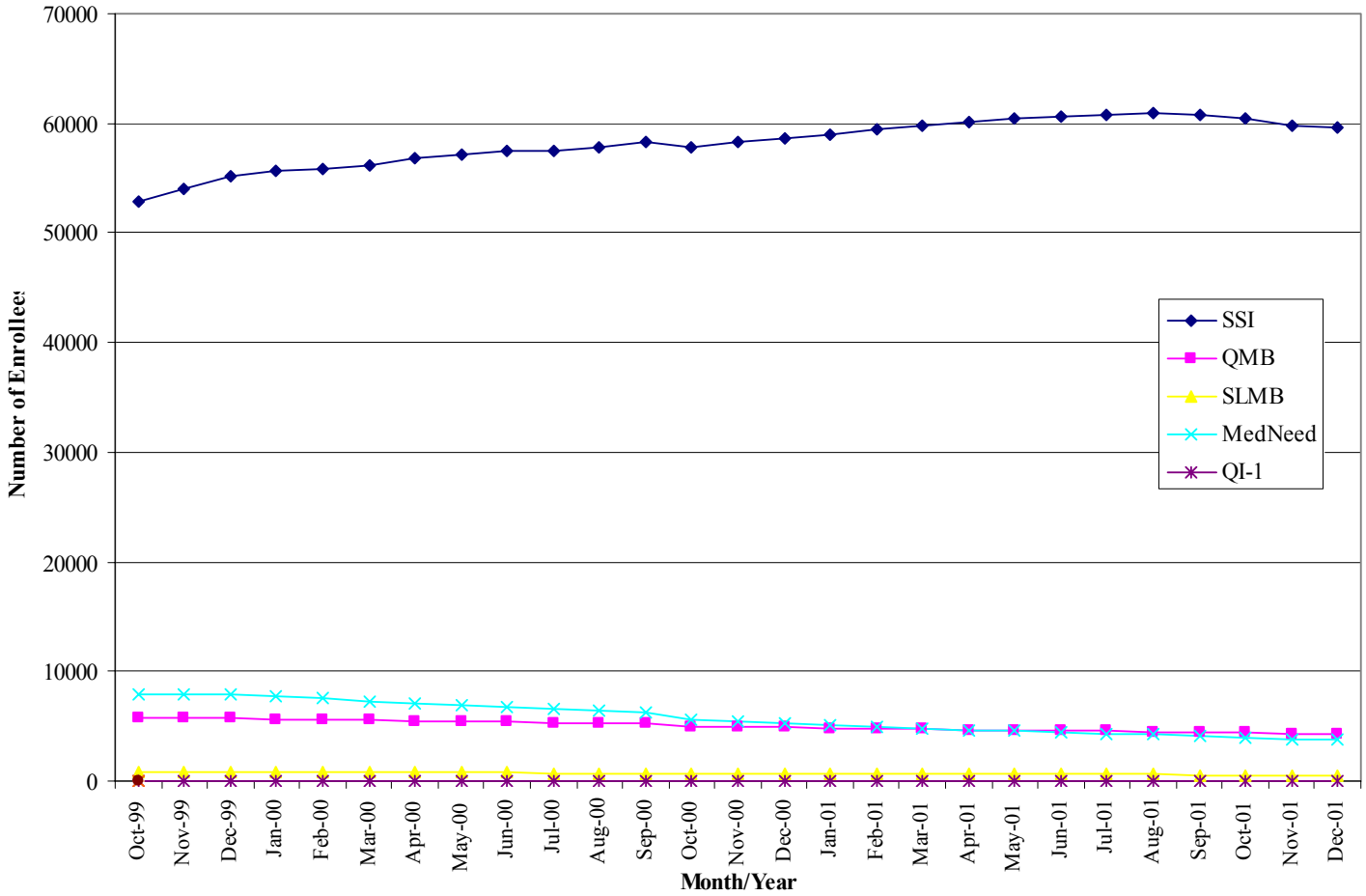
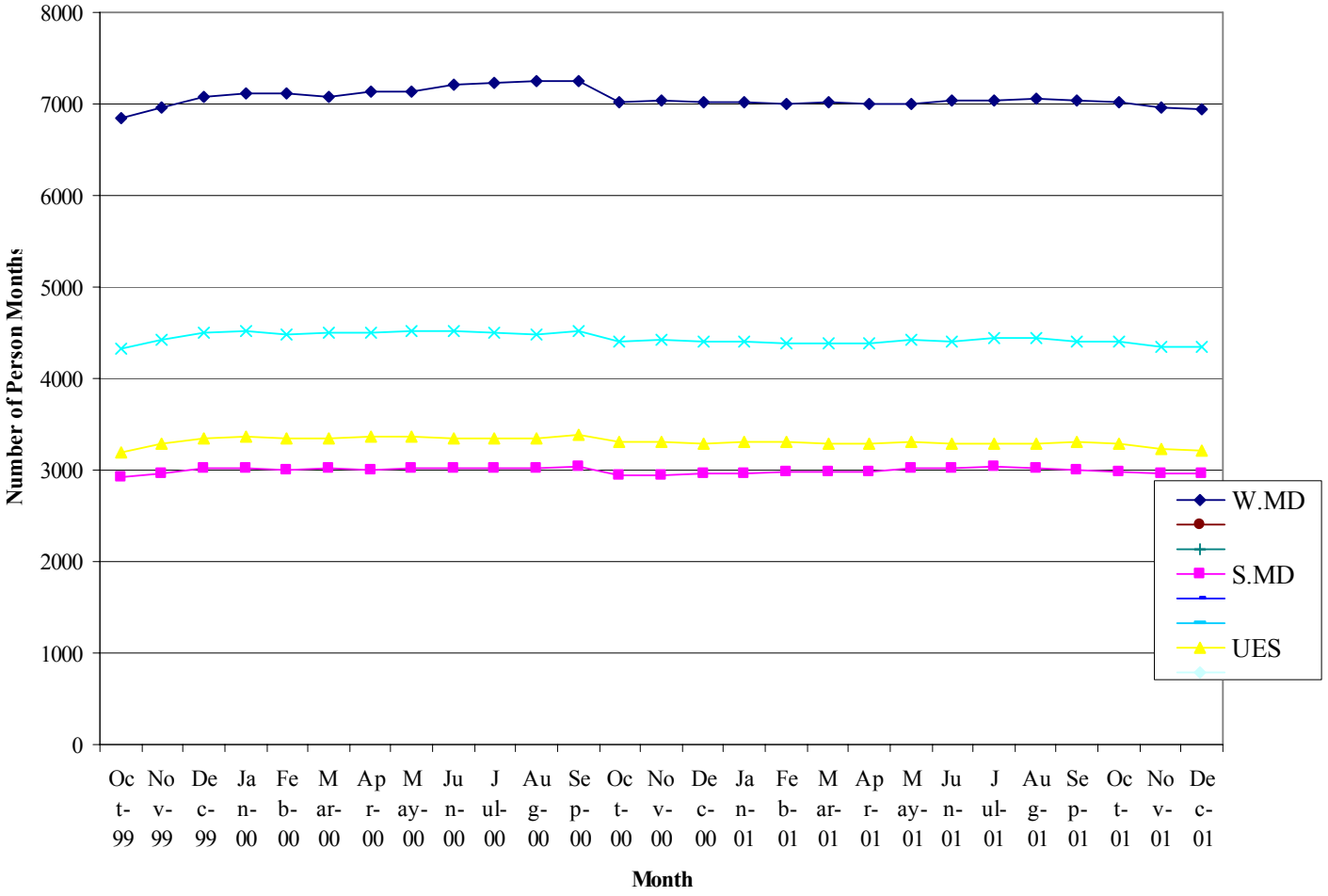


Figure C-3

Maryland: Number of Enrollees by Month and Region
October 1999 - December 2001

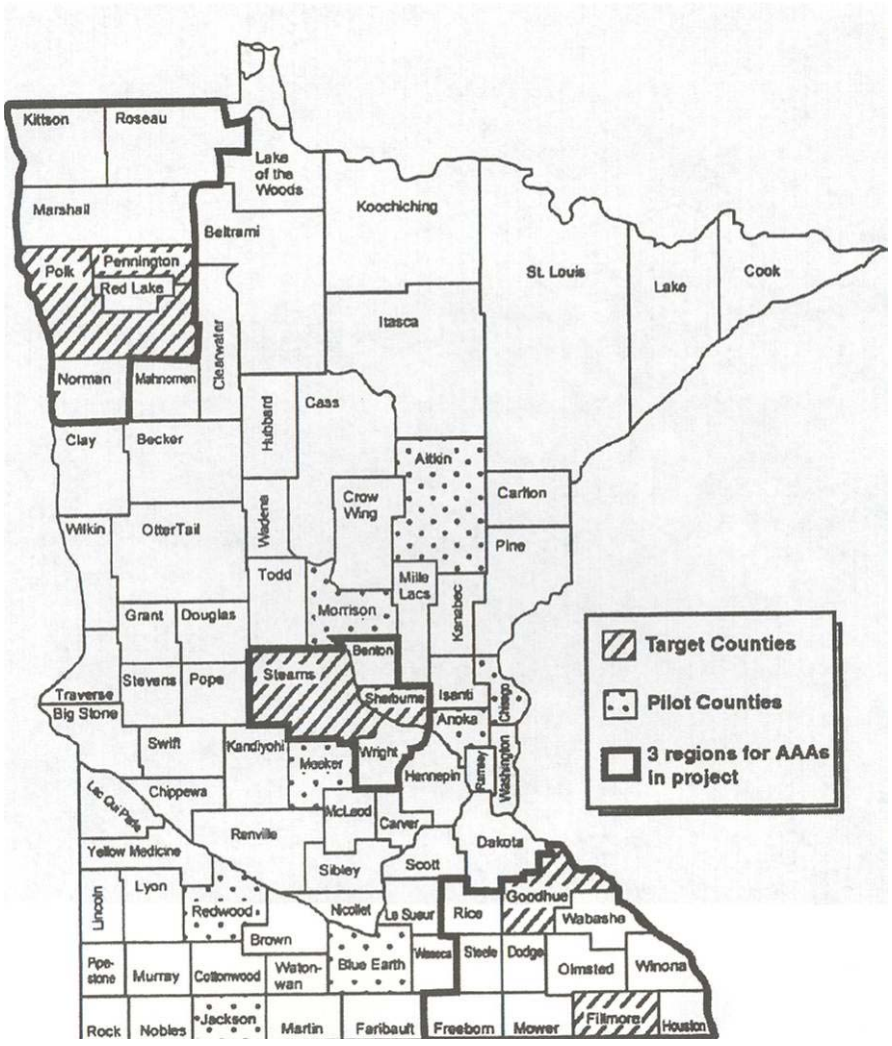


APPENDIX D

MINNESOTA

Map of Minnesota

Figure D-1


Kittson
Roseau
Lake of the Woods
Koochiching
Marshall
Beltrami
St. Louis
Lake
Cook
Polk
Pennington
Red Lake
Itasca
Clearwater
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Aitkin
Carlton
Wilkin
OtterTail
Wadena
Crow Wing
Pine
Todd
Mille Lacs
Kanabec
Grant
Douglas
Morrison
Benton
Stearns
Traverse
Stevens
Pope
Sherburne
Isanti
Chisago
Big Stone
Anoka
Swift
Kandiyohi
Meeker
Wright
Hennepin
Ramsey
Washington
Lac Qui Parle
Chippewa
McLeod
Carver
Renville
Dakota
Yellow Medicine
Sibley
Scott
Lincoln
Lyon
Redwood
Nicollet
Le Sueur
Rice
Goodhue
Wabasha
Brown
Pipestone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
Target Counties
Pilot Counties
3 regions for AAAs in project

Minnesota

Enrollment Application and Outreach Materials

DHS-3417 (4/01)

Minnesota Health Care Programs Application

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجّانيّة في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعيّة أو اتصل بالرقم (من داخل المدينة وضواحيها) 763-569-1802 أو (من خارج المدينة وضواحيها) بالرقم 1-800-358-0377

កំណត់សំគាល់ បើអ្នកចង់ចាន់ជំនួយបកប្រែកំមានន្ទេះដោយមិនគិតថ្លៃ សូមសួរអ្នកការងារសង្គមរបស់អ្នក ឬទូរស័ព្ទទៅ [ឈ្មោះអង្គការ] លេខ (ក្នុងក្រុង) 612-728-7314 ឬ (ក្រៅក្រុង) 1-888-468-3787។

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) los sis hu (hauv nroog metro) 612-728-7315 los (sab nrauv) 1-888-486-8377.

ຂະອັຖ, ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມຄັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມບໍ່ານັກງານຊ່ວຍວຽກ ຂອງທ່ານ ຫຼື ໂທຣຫາ ຕາມເລກໂທຣ (ພາຍໃນເຂດກໍ່ານະຄອນ) 612-728-7316 ຫຼື (ນອກເຂດກໍ່ານະຄອນ) 1-888-487-8251.

Внимание: Если Вам нужна бесплатная помощь в переводе этой информации, обратитесь к прикреплённому к Вам сотруднику или позвоните по телефонам: 651-695-4011 (Миннеаполис, Сент-Пол и окрестности) или 1-888-562-5877 (другие районы штата Миннесота).

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani, weydii adeeg hayaha ama wac ee (magalada) 612-728-7318 ama (Gobolka intiisa kale) 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 612-341-7200 (en el área metropolitana) o al 1-888-428-3438 (fuera del área metropolitana).

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 612-728-7317 (nếu ở thành phố) hoặc 1-888-554-8759 (nếu ở ngoài tiểu-bang).

Health Care Programs Application

Read these instructions before you fill out the application.

Dear Applicant,

This is your Minnesota Health Care Programs Application. Complete, sign and date your form. A worker will process your application and decide which program will provide the best health coverage for you and your family.

If you cannot answer all questions without help, fill out what you can and turn in the form. Make sure you sign and date the form. If you are mailing your application, extra postage is required. If we need more information, a worker will write or call you. **If you would like to meet with a worker, please call your local county agency or MinnesotaCare for an appointment.**

When you fill out the application:

- ☐ Answer all questions completely. **If you need more space, use a separate sheet of paper.**
- ☐ Sign and date the form.
- ☐ Send proof of all income, such as copies of pay stubs from the past 30 days. If self-employed, send a copy of your most recent federal income tax forms and all related schedules.
- ☐ Send a copy of both sides of immigration cards or other documents that show immigration status for every family member who is not a U.S. citizen and is applying. **We will not contact the Immigration and Naturalization Service (INS) without your written permission.**

Mail or bring the completed application and all needed items to:

- Your local county human services agency.

If you want to apply for MinnesotaCare only:

- Send your application to MinnesotaCare, PO Box 64838, St. Paul, MN 55164-0838 *or*
- Bring your application to MinnesotaCare, 8 Fourth Street, St. Paul, MN *or*
- Contact your local county agency to see if they will process your MinnesotaCare application.

It is important to get your application in as soon as possible because some health programs cover past medical costs. Once we receive all information, you will get a written notice about your eligibility.

Minnesota offers several different programs that may cover your family's health care needs.

Medical Assistance (MA) — Medical coverage for families with children, pregnant women, people 65 and over and disabled persons.

Qualified Medicare Beneficiary (QMB) — Pays some Medicare expenses, such as premiums, copayments and deductibles.

Service Limited Medicare Beneficiary (SLMB) — Pays Medicare Part B premiums.

Prescription Drug Program — Pays for prescription drugs for people 65 and over.

General Assistance Medical Care (GAMC) — Medical coverage for adults without children, undocumented children and undocumented adults who are 65 and over, blind or disabled.

MinnesotaCare — Medical coverage for families with children and adults without children. You pay a monthly premium based on your family size, income and other circumstances.

If you have any questions about this form or the proofs you need to send, please call:

- Your local county human services agency or MinnesotaCare at 651-297-3862 or 1-800-657-3672
- Prescription Drug Program: Your local county human services agency or Senior LinkAge Line® at 1-800-333-2433

Read this page. Tear off. Keep for your records.

Your Rights and Responsibilities

Your Privacy Rights

You have privacy rights under the Minnesota Government Data Practices Act. This protects your privacy, but also lets us give information about you to others if a law requires it. We will tell you before we give information.

Why do we ask you for this information?

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services
- To decide if you can pay for some of your services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your family need protective services
- To collect money from the state or federal government for help we give you

Do you have to answer the questions we ask?

Generally the law does not say you have to give us this information. Federal law requires that you give us your Social Security number if you want financial help or child support enforcement.

What will happen if you do not answer the questions we ask?

We need information about you to tell if you can get help. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share information about you?

We may give information about you to the following agencies, if they need it for investigations or to help you or help us help you. We don't always share information about you with these people, but the law says we may share data with them. If you have questions about when we give these people information, ask your worker.

- Minnesota Department of Human Services
- Other welfare offices, including child support enforcement offices
- Mental health centers
- State hospitals or nursing homes
- Ombudsman for mental health and mental retardation
- Insurance companies to check benefits you or your children may get
- Hospitals, if you, a friend or relative has an emergency and we need to contact someone
- Internal Revenue Service
- County welfare boards
- Minnesota Department of Public Safety
- Collection agencies, if you do not pay fees you owe us for services
- Fraud prevention and control units
- Anyone under contract with the Minnesota Department of Human Services or U.S. Department of Health and Human Services, or the county social services agency
- U.S. Department of Labor and Minnesota Department of Labor and Industry
- U.S. Department of Agriculture
- Immigration and Naturalization Service
- Social Security Administration
- Minnesota Department of Economic Security
- Minnesota Department of Revenue
- Credit bureaus
- Minnesota Department of Veteran Affairs
- Minnesota Department of Human Rights
- Others who may pay for your care
- County attorney, attorney general or other law enforcement officials
- Community food shelves or surplus food programs
- State and federal auditors
- Schools and colleges
- Local collaborative agencies
- Guardian, conservator or person who has power of attorney for you
- Minnesota Historical Society
- Ombudsman for families
- Creditors
- School districts
- Local and state health departments
- American Indian tribes, if your children are Indian and in need of out-of-home placement, employment, training or welfare services at a tribal reservation
- Employees or volunteers of any welfare agency who need the information to do their jobs
- People who investigate child or adult protection
- Court officials
- Coroner/medical examiner if you die and they investigate your death
- Anyone else the law says we can give the information

Read this page. Tear off. Keep for your records.

You have the right to information we have about you.

- You may ask if we have any information about you and get copies. You may have to pay for the copies.
- You may give other people permission to see and have copies of private data about you.
- If you do not understand the information, you may ask to have it explained to you.
- You may question the accuracy of any information we have about you.

What if you question the information?
Send your questions in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

What privacy rights do children have?
If you are under 18, parents may see data about you and allow others to see this data, unless you have asked that this information not be shared with your parents, or it involved medical treatment in which parental consent was not required. You must make this request in writing and say what data you want withheld and why. If the agency agrees that sharing the data is not in your best interest, the data will not be shared with your parents. If the agency does not agree, the data will be shared with your parents if they ask for it. When parental consent for medical treatment is not required, data will not be shown to parents unless the health care provider believes failing to share the data would jeopardize the health of the child.

Your Rights

Fair Treatment
You have the right to fair treatment. Minnesota Health Care Programs (MHCP) cannot treat you differently because of your race; color; national origin; religion; sex; marital status; sexual orientation; political beliefs; or because of physical, mental or emotional disability. If you feel the state or local agency did not treat you fairly for any of these reasons, you may file a complaint with the Minnesota Department of Human Services, 444 Lafayette Road N., St. Paul, MN 55155, or the Minnesota Department of Human Rights, Army Corps of Engineers Centre, 190 E. Fifth Street, Suite 700, St. Paul, MN 55101.

Appeal Rights
If you are unhappy with an action taken, or you feel the agency did not act on your application, you may ask for a fair hearing. You must ask for the hearing within 30 days from the date of the agency notice. You can ask for a hearing by telling your worker or by writing to the State Appeals Office at the Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155-3813. If you appeal after 30 days, the hearing officer will schedule a hearing and decide if you had a good reason for requesting your hearing late. If you want your coverage to continue until the hearing, you must appeal before the date of the proposed action, or within 10 days from the date of the agency notice, whichever is later.

Your Responsibilities

Quality Control Reviews
The State or Federal Quality Control Agency may randomly choose your case for review. They will review statements you have made on forms. They will check to see if we figured your eligibility correctly. The Federal Quality Control Agency will tell you about any contact they intend to make. If you do not cooperate, you may lose benefits.

Social Security Numbers
Most people who apply for coverage must provide a Social Security number (SSN). We use SSNs to do identity checks, computer matches, program reviews and audits to make sure eligibility for Minnesota Health Care Programs is correct. You do not have to provide an SSN if you do not want coverage or if you are a non-citizen applying only for emergency medical assistance.

Changes
You must report changes to your worker within 10 days, including:

- Pregnancy
- Births
- Deaths
- Change in income
- Employment
- Change of address
- Change in health insurance
- Marriages
- Divorces
- Family members moving in or out of your household

OFFICE USE ONLY
DATE RECEIVED:
CASE NUMBER:
WORKER NUMBER:

Please Print in Ink

1. Tell us who you are and where you live.

LAST NAME	FIRST NAME	MI	PHONE NUMBER WHERE YOU CAN BE REACHED ( )
STREET ADDRESS / APT #	CITY	STATE	ZIP
MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS)		COUNTY YOU LIVE IN	
DATE OF BIRTH	SEX ☐ M ☐ F	WHAT IS YOUR PRIMARY LANGUAGE?	DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO
DO YOU WANT US TO SEND YOU A VOTER'S REGISTRATION CARD? ☐ YES ☐ NO	ARE YOU APPLYING FOR YOURSELF? ☐ NO ☐ YES IF NO, GO TO #2 IF YES, CONTINUE →	SOCIAL SECURITY NUMBER	PREGNANT? ☐ YES ☐ NO
STUDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE

2. Tell us if you want someone to act on your behalf.

You may have a person age 18 or older act on your behalf to help you fill out forms and provide information we need. You can choose a friend, relative or someone can be appointed by the courts. They can receive notices and pay your MinnesotaCare premiums. ☐ NO—GO TO QUESTION 3 ☐ YES—CONTINUE

NAME	RELATIONSHIP TO YOU	PHONE ( )	
STREET ADDRESS	CITY	STATE	ZIP

Do you want this person to get all correspondence? ☐ YES ☐ NO

3. Tell us about other family members who want to apply.

LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO YOU	SEX ☐ M ☐ F	PREGNANT? ☐ YES ☐ NO
STUDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE	
LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO YOU	SEX ☐ M ☐ F	PREGNANT? ☐ YES ☐ NO
STUDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE	
LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO YOU	SEX ☐ M ☐ F	PREGNANT? ☐ YES ☐ NO
STUDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE	

Go to form C if you need to list more family members who want to apply.

4. Tell us if anyone applying has a spouse, parent, child or sibling living in the home.

(Do not include people already listed.)

NAME	DATE OF BIRTH	RELATIONSHIP TO YOU
NAME	DATE OF BIRTH	RELATIONSHIP TO YOU
NAME	DATE OF BIRTH	RELATIONSHIP TO YOU
NAME	DATE OF BIRTH	RELATIONSHIP TO YOU

5. Tell us if all family members listed are living in your home.

Are all family members listed living in your home? ☐ YES ☐ NO, LIST WHERE THEY LIVE

NAME	ADDRESS
NAME	ADDRESS

6. Tell us about your children.

Do any of the children listed have a parent that does not live with them?

☐ YES, LIST CHILDREN BELOW ☐ NO, GO TO QUESTION 7

CHILD'S NAME	CHILD'S NAME
CHILD'S NAME	CHILD'S NAME

7. Tell us if all family members applying are U.S. citizens.

Are all family members applying U.S. citizens? ☐ YES — GO TO QUESTION 8 ☐ NO — CONTINUE

NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO
NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO
NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO
NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO

Are any of the persons listed receiving care and services from the Center for Victims of Torture? ☐ YES ☐ NO

Go to form C if you need to list more family members. Remember to send a copy of both sides of immigration cards or copies of other verifying documents.

8. Tell us about the health needs of you and your family.

Is anyone applying getting medical treatment from an accident or injury that happened in the last six years?
☐ NO ☐ YES, WHO? _____
Is a lawsuit pending due to this accident or injury? ☐ NO ☐ YES

Is anyone applying seriously ill, disabled or blind? ☐ NO ☐ YES, WHO?
(If yes, additional medical services may be available.)

Some Minnesota Health Care Programs may pay for health care you received up to three months before you apply. **Write the month you would like coverage to start:**

9. Tell us if you or anyone in your family is employed.

Is anyone working? ☐ NO ☐ YES—FILL IN FOR EACH PERSON WORKING

FIRST NAME	EMPLOYER	HOURS WORKED PER WEEK	WAGE $	☐ MONTHLY ☐ HOURLY
FIRST NAME	EMPLOYER	HOURS WORKED PER WEEK	WAGE $	☐ MONTHLY ☐ HOURLY
FIRST NAME	EMPLOYER	HOURS WORKED PER WEEK	WAGE $	☐ MONTHLY ☐ HOURLY

Send wage stubs from the past 30 days.

10. Tell us if you or anyone in your family is seasonally employed.

Is anyone seasonally employed? ☐ NO ☐ YES—FILL IN FOR EACH PERSON SEASONALLY EMPLOYED

FIRST NAME	EMPLOYER	NUMBER OF MONTHS WORKED PER YEAR	YEARLY SEASONAL WAGES $
FIRST NAME	EMPLOYER	NUMBER OF MONTHS WORKED PER YEAR	YEARLY SEASONAL WAGES $

Send wage stubs from the past 30 days or other proof of wages.

11. Tell us if you or anyone in your family is self-employed.

Is anyone self-employed? ☐ NO ☐ YES—FILL IN FOR EACH PERSON SELF-EMPLOYED

FIRST NAME	START DATE OF BUSINESS	YEARLY INCOME AFTER BUSINESS EXPENSES $	DEPRECIATION AMOUNT FROM LAST YEAR'S TAXES
FIRST NAME	START DATE OF BUSINESS	YEARLY INCOME AFTER BUSINESS EXPENSES $	DEPRECIATION AMOUNT FROM LAST YEAR'S TAXES

Send a copy of the most recent federal income tax forms and all related schedules.

12. Tell us if you or anyone in your family gets or expects to get income from:

- Social Security
- Supplemental Security Income (SSI)
- veteran's benefits
- pensions
- interest
- dividends
- rental property
- worker's compensation
- re-employment insurance
- child support
- alimony
- other

☐ NO ☐ YES — LIST INCOME BELOW

NAME	TYPE OF INCOME	MONTHLY AMOUNT $
NAME	TYPE OF INCOME	MONTHLY AMOUNT $
NAME	TYPE OF INCOME	MONTHLY AMOUNT $

Send proof of this income.

13. Tell us about your family's expenses.

Is anyone paying for child care while you work? ☐ NO ☐ YES—WHO?	MONTHLY AMOUNT $
Is anyone paying for the care of an ill or disabled adult while you are at work? ☐ NO ☐ YES—WHO?	MONTHLY AMOUNT $
Is anyone paying court-ordered child or medical support? ☐ NO ☐ YES—WHO?	MONTHLY AMOUNT $

14. Tell us more about those who are applying.

Is anyone applying 21 or older and not pregnant? ☐ YES ☐ NO	**If you answered YES, fill out form A. Do not complete form A if you and all family members are applying for MinnesotaCare only.**

15. Tell us if you or anyone in your family has health insurance.

Is anyone covered under health insurance, Medicare or prescription drug coverage? ☐ NO ☐ YES	**If you answered YES to any of these questions, fill out form B.**
Has anyone had health insurance or prescription drug coverage in the past four months? ☐ NO ☐ YES	
Is anyone working for an employer who offers health insurance or has offered it in the past? ☐ NO ☐ YES	

Read the following and sign and date this form.

Fraud Investigation Release
I give third parties permission to share information about me with authorized county staff conducting a fraud prevention investigation. Third parties include financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies and others. I understand that my permission for release is effective until six months after my benefits stop.

Medical Assignment
I assign to the state of Minnesota any medical care payments I have a right to under automobile or health insurance. I assign all rights to medical support payments from a noncustodial parent of any child(ren) who receive MA or MinnesotaCare coverage under this application. I agree to cooperate with the state, unless my claim for good cause is granted, in any legal action brought against a third party for payment of medical expenses.

Medical Release
I give my medical providers, including my health plan, permission to release to the state of Minnesota, its agents or contractors, any medical records developed while I get coverage from Minnesota Health Care Programs (MHCP). I understand the state of Minnesota needs this information to pay my medical providers; decide if I am eligible for federally funded medical care; conduct quality of care and performance reviews; assure coordination of medical services; and assist in record review investigations, prosecutions, or legal proceedings related to the administration of the programs. If I have Medicare Part B, I give Medicare permission to directly pay my medical providers for any services while I get MHCP coverage. This also applies to the records of my minor dependents. I understand I may be contacted to answer questions about health care I have received and I may be selected for a survey based on services I receive.

If you are not eligible for MinnesotaCare, do you want this application sent to your county agency for possible coverage from other health care programs? ☐ YES ☐ NO

Declaration and signature

I declare under the penalties of perjury that I have examined all parts of this application and, to the best of my knowledge it is a true and correct statement. I have read and understand my rights and responsibilities. I understand that a person convicted of perjury may be sentenced to imprisonment up to five years or a fine not more than $10,000, or both.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF SPOUSE OR SECOND APPLICANT	DATE
SIGNATURE OF PERSON ACTING ON YOUR BEHALF	DATE

Property Information

Complete this information if anyone applying is 21 or older and not pregnant. There may be limits to the amount of assets you may own. Some property is not counted, including the house you live in, your primary vehicle and most burial accounts.

Assets

Tell us if you or anyone in your family owns any of the following assets, such as:

- annuities
- burial accounts
- cash, checking, savings
- certificates of deposit
- contracts for deed
- credit union account
- houses you do not live in
- land you do not live on
- life estates
- life insurance
- money market accounts
- retirement accounts
- stocks, bonds
- trusts
- other

Check this box if you do not have any assets: ☐

OWNER	TYPE OF PROPERTY	VALUE $
OWNER	TYPE OF PROPERTY	VALUE $
OWNER	TYPE OF PROPERTY	VALUE $
OWNER	TYPE OF PROPERTY	VALUE $
OWNER	TYPE OF PROPERTY	VALUE $
OWNER	TYPE OF PROPERTY	VALUE $
OWNER	TYPE OF PROPERTY	VALUE $
OWNER	TYPE OF PROPERTY	VALUE $

Vehicles

Tell us if you or anyone in your family owns or are purchasing any vehicles, such as: (Do not list vehicles used for business purposes only.)

- all-terrain vehicles
- campers
- cars
- boats, motors, trailers
- farm implements
- jet skis
- trucks
- motorcycles
- snowmobiles

Check this box if you do not have any vehicles: ☐

OWNER	TYPE	MAKE/MODEL/YEAR	VALUE $
OWNER	TYPE	MAKE/MODEL/YEAR	VALUE $
OWNER	TYPE	MAKE/MODEL/YEAR	VALUE $
OWNER	TYPE	MAKE/MODEL/YEAR	VALUE $

Transfers

Tell us if you or anyone in your family has given away, sold or traded any assets in the last 60 months, such as:

- buildings
- burial funds
- cash
- contracts for deed
- land
- life estates
- mobile homes
- other property
- stocks/bonds
- vehicles

Check this box if you did not transfer any assets: ☐

OWNER	ITEM TRANSFERRED	DATE TRANSFERRED	VALUE $
OWNER	ITEM TRANSFERRED	DATE TRANSFERRED	VALUE $

Form B

Other Health Insurance and Medicare Coverage

A. Health Insurance: Complete if anyone applying has health insurance or prescription drug coverage now or in the past four months. If you have more than one policy, provide the same information on a separate piece of paper for the additional policies. You may send a copy of both sides of all health insurance cards instead of completing Section A.

POLICYHOLDER'S NAME	DATE OF BIRTH	POLICY TYPE ☐ INDIVIDUAL ☐ EMPLOYER/GROUP		POLICY NUMBER:	
INSURANCE COMPANY NAME	PHONE NUMBER ( )	POLICY BEGIN DATE		POLICY END DATE	
CLAIMS ADDRESS		CITY		STATE	ZIP
EMPLOYER/GROUP NAME		EMPLOYER/GROUP NUMBER			
EMPLOYER/GROUP ADDRESS		CITY		STATE	ZIP
LIST FAMILY MEMBERS COVERED					
DEDUCTIBLES (NOT COPAY)	$ _____ PER PERSON IN NETWORK		$ _____ PER FAMILY IN NETWORK		
	$ _____ PER PERSON OUT OF NETWORK		$ _____ PER FAMILY OUT OF NETWORK		
OFFICE COPAY		PRESCRIPTION COPAY			

B. Health insurance through an employer: Complete if anyone applying has current health insurance through a job or has had health insurance available through a job in the past 18 months. (Check all that apply.)

- ☐ I/we have health insurance through an employer.
- ☐ Insurance was offered by a current employer, but I/we did not take it.
- ☐ I/we had health insurance through a current employer. The insurance ended:_____/_____/_____.
  Reason insurance ended: _____.
- ☐ An employer offered health insurance in the past 18 months.
- ☐ The employer stopped offering insurance as a benefit for employees on: _____/_____/_____.

What is or was the cost of the insurance checked above?
(You may have to contact the employer to answer these questions.)

EMPLOYEE	EMPLOYER/UNION PAYS $	☐ MONTHLY ☐ TWICE A MONTH ☐ WEEKLY ☐ EVERY 2 WEEKS
	AMOUNT YOU PAY $	☐ MONTHLY ☐ TWICE A MONTH ☐ WEEKLY ☐ EVERY 2 WEEKS
SPOUSE/DEPENDENT	EMPLOYER/UNION PAYS $	☐ MONTHLY ☐ TWICE A MONTH ☐ WEEKLY ☐ EVERY 2 WEEKS
	AMOUNT YOU PAY $	☐ MONTHLY ☐ TWICE A MONTH ☐ WEEKLY ☐ EVERY 2 WEEKS

C. Medicare: Complete if anyone applying has Medicare coverage.

PERSON COVERED	MEDICARE ID NUMBER	START DATE OF PART A	START DATE OF PART B
PERSON COVERED	MEDICARE ID NUMBER	START DATE OF PART A	START DATE OF PART B

Use this page only if you need more space to tell us who else is applying.

Tell us about other family members who want to apply.

LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO YOU	SEX ☐ M ☐ F	PREGNANT? ☐ YES ☐ NO
STUDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE	

LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO YOU	SEX ☐ M ☐ F	PREGNANT? ☐ YES ☐ NO
STUDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE	

NAME		FIRST NAME		MI
CIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO YOU	SEX ☐ M ☐ F	PREGNANT? ☐ YES ☐ NO
UDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE	

LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO YOU	SEX ☐ M ☐ F	PREGNANT? ☐ YES ☐ NO
STUDENT? ☐ NO ☐ FULL-TIME ☐ PART-TIME	LIVED IN MINNESOTA FOR THE LAST SIX MONTHS? ☐ YES ☐ NO	HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO	RACE (OPTIONAL): ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN ☐ WHITE	

Tell us if all family members applying are U.S. citizens.

Are all family members applying U.S. citizens? ☐ YES — GO TO QUESTION 8 ☐ NO — CONTINUE

NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO
NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO
NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO
NAME	IMMIGRATION STATUS	DATE OF ENTRY INTO U.S.	DOES THIS PERSON HAVE A SPONSOR? ☐ YES ☐ NO

Are any of the persons listed receiving care and services from the Center for Victims of Torture? ☐ YES ☐ NO

Remember to send a copy of both sides of immigration cards or copies of other verifying documents.

Form C

C

This information is available in other forms to people with disabilities by contacting us at (651) 296-8517 (voice), toll free at 1-800-657-3659, or through the Minnesota Relay Service at 1-800-627-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay service).

Important Information for **Medicare Enrollees**

This information is available in other forms to people with disabilities by contacting us at (651) 296-8517 (voice), toll free at 1-800-657-3659, or through the Minnesota Relay Service at 1-800-627-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay service).

Medical Assistance for Qualified Individuals

Minnesota Department of Human Services

DHS-2087I(4-01)

Minnesota Department of **Human Services**
www.dhs.state.mn.us

The Qualified Individuals (QI) Program can help people pay their Medicare Part B premiums or a portion of the Part B premiums. QI is funded by the Federal government as part of the Medical Assistance (MA) Program. QI is available for a limited time on a first-come, first-served basis.

How can I get QI benefits?

You may get QI benefits if:

- Your assets are not worth more than the QI asset limits,
- Your income, after all allowable deductions, meets the QI standards,
- You are enrolled (or eligible to enroll) in Medicare Part A and B, AND
- You apply while funding is available for the program.

How do I apply for QI?

Call, write or go to the county human services agency in the county where you live and ask to apply for QI.

What are the QI income limits and benefits?

If your income after certain disregards and deductions is not more that the QI income limits, you can get QI. Contact your county for information about these deductions.

QI income limits and benefits are divided into two groups:

Qualified Individuals - Group 1 (QI-1) are eligible for full Part B premium payment. If you qualify for QI-1, this program will pay your Medicare Part B premium directly to Medicare. If the Part B premium is now being deducted from your Social Security check , your check will go up when you get QI. If you are enrolled in Part A and are not enrolled in Part B, you will be enrolled in Part B when you get QI.

The gross* income limit for QI-1 is:

Qualified individuals - Group 1

135% of FPG • Effective April 1, 2001 - March 31, 2002

Family Size	Annual Standard	Monthly Standard	Family Size	Annual Standard	Monthly Standard
1	$11,844	$ 987	7	36,300	3,025
2	15,924	1,327	8	40,380	3,365
3	19,992	1,666	9	44,460	3,705
4	24,072	2,006	10	48,540	4,045
5	28,152	2,346	Additional	4,320	360
6	32,232	2,686			

*Social Security gross income is your benefit **before** premiums or other amounts are subtracted

Qualified Individuals - Group 2 (QI-2) are eligible for partial payment of the Medicare Part B premiums ($3.09 per month in 2001). If you qualify for QI-2, the state will pay you on an annual basis for each month that you were eligible in the prior year (up to $37.08).

The gross* income limit for QI-2 is:

Qualified individuals - Group II

175% of FPG Effective April 1, 2001 - March 31, 2002

Family Size	Annual Standard	Monthly Standard	Family Size	Annual Standard	Monthly Standard
1	$15,276	$1,273	7	46,992	3,916
2	20,568	1,714	8	52,272	4,356
3	25,848	2,154	9	57,564	4,797
4	31,128	2,594	10	62,844	5,237
5	36,420	3,035	Additional	5,532	461
6	41,700	3,475			

*Social Security gross income is your benefit **before** premiums or other amounts are subtracted

What are the QI asset limits?

Assets are what you own including cash, savings, and non-homestead property. A person living alone may own $10,000 in assets. A married couple or family may own $18,000 in assets.

Some assets that do not count are:

- Homestead property,
- Mobile home used as your primary home,
- Prepaid burial fund up to $1,500,
- Burial space items,
- One motor vehicle under certain conditions.

If you live with your spouse, your spouse's income and assets also count even if your spouse does not want to apply for QI.

If your household includes your stepparent, the income and assets of your stepparent do not count. The income and assets of a child do not count when deciding the eligibility of their parents or brothers and sisters.

For more information

The information above can help you decide if you wish to apply for QI. ***It does not cover all the program rules.*** Your county agency will need all the facts about your situation before they can determine if you are eligible.

Even if you are not sure whether or not you may be eligible, you should apply as soon as possible.

For more information about Medical Assistance, contact your county human services agency or call Senior LinkAge Line® at 1-800-333-2433. You can also check out our website at: www.dhs.state.mn.us/infocenter or www.dhs.state.mn.us/hlthcare.

Important Information for **Medicare Enrollees**

Medical Assistance for Service Limited Medicare Beneficiaries

Minnesota Department of **Human Services**
www.dhs.state.mn.us

DHS-2087G (7/01)

The Service Limited Medicare Beneficiaries (SLMB) Program can help people pay their Medicare Part B premiums. SLMB is funded by the State of Minnesota and the Federal government as part of the Medical Assistance (MA) Program.

Can I get SLMB benefits?

You may get SLMB benefits if:

- Your assets are not worth more than the SLMB asset limits,
- Your income, after allowable deductions, meets the SLMB income standards, and
- You are enrolled (or eligible to enroll) in Medicare Part A and B.

How do I apply for SLMB?

Call, write, or go to the county human services agency in the county where you live and ask to apply for SLMB.

Medicare enrollment

The SLMB program will pay your Medicare Part B premium directly to Medicare. If the Part B premium is now being deducted from your Social Security or Railroad check, your check will go up when you get SLMB. If you are enrolled in Part A and are not enrolled in Part B, you will be enrolled in Part B when you get SLMB.

If you are over 65 and are not enrolled in Medicare Part A or Part B, contact your Social Security office to find out how to apply.

What are the SLMB income limits?

If your income after certain disregards and deductions is not more than the SLMB income limits, you can get SLMB. See your county financial worker for information about these deductions.

SLMB gross* income limits

April 1, 2001 - March 31, 2002

Family Size	Monthly Income
1	$ 879
2	1,181
3	1,483
4	1,785
5	2,087
6	2,389
7	2,691
8	2,993
Additional	322

Social Security gross income is your benefit* **before *premiums or other amounts are subtracted*

What are the SLMB asset limits?

Assets are what you own including cash, savings, and non-homestead property. A person living alone may own $10,000 in assets. A married couple or family may own $18,000 in assets.

Some assets that do not count are:

- Homestead property,
- Mobile home used as your primary home,
- Prepaid burial fund up to $1500,
- Burial space items,
- One motor vehicle under certain conditions.

Other income and asset guidelines

If you live with your spouse, your spouse's income and

assets also count even if your spouse does not want to apply for SLMB. If you are under age 21 and living with your parents, your parents' income and assets also count even if your parents do not want to apply for SLMB. **If you have a disability and are between the ages of 18 and 21, your parents' income does not count.**

If your household includes your stepparent, the income of your stepparent does not count. The income and assets of a child do not count when deciding the eligibility of their parents or brothers and sisters.

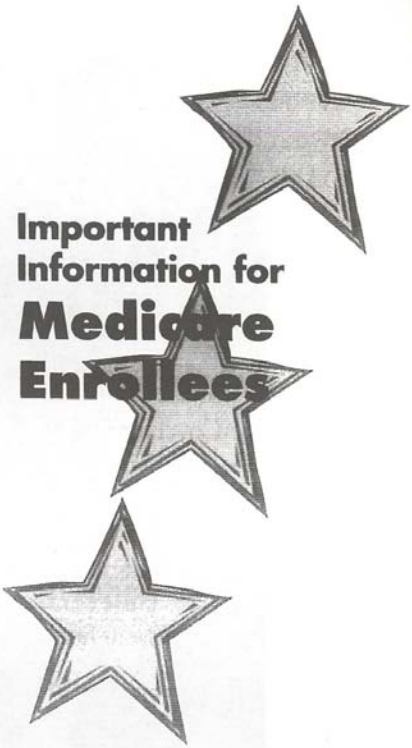
For more information

The information above can help you decide if you wish to apply for SLMB. ***It does not cover all of the program rules.*** Your county agency will need all the facts about your situation before they can determine if you are eligible.

Even if you are not sure whether or not you may be eligible, you should apply as soon as possible.

For more information about MA **contact your county human services agency or call Senior LinkAge Line® at 1-800-333-2433.** You can check out our website at: www.dhs.state.mn.us/infocenter or www.dhs.state.mn.us/hlthcare

This information is available in other forms to people with disabilities by contacting us at (651) 296-8517 (voice), toll free at 1-800-657-3659, or through the Minnesota Relay Service at 1-800-627-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay service).



Important Information for Medicare Enrollees

This information is available in other forms to people with disabilities by contacting us at (651) 296-8517 (voice), toll free at 1-800-657-3659, or through the Minnesota Relay Service at 1-800-627-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay service).

Medical Assistance for Qualified Medicare Beneficiaries

Minnesota Department of **Human Services**

www.dhs.state.mn.us

Minnesota Department of Human Services

DHS-2087E (7/01)

The Qualified Medicare Beneficiaries (QMB) Program can help people pay their:

- Medicare Part A premiums,
- Medicare Part B premiums,
- Medicare deductibles,
- Medicare co-insurance and co-payments.

QMB is part of the Medicare Catastrophic Coverage Act of 1988. It is funded by the State of Minnesota and the Federal government.

Can I get QMB benefits?

You may get QMB benefits if:

- Your assets are not worth more than the QMB asset limits,
- Your income, after allowable deductions, meets the QMB income standards,
- You are willing to assign any medical insurance benefit rights to the Minnesota Department of Human Services, and
- You are eligible to enroll in Medicare Part A coverage.

How do I apply for QMB?

Call, write, or go to the county human services agency in the county where you live and ask to apply for QMB.

Medicare Part A enrollment

If you are enrolled in Medicare Part B, you will also be enrolled in Medicare Part A by applying for QMB if you:

- Are within three months of your 65th birthday,
- Are less than 65 years of age and have received a Social Security disability check for the last 24 months, or
- Need kidney dialysis or kidney replacement.

If you are over 65 and are not enrolled in Medicare Part A or Part B, contact your Social Security office to find out when you can apply.

What are the QMB income limits?

If your income after certain disregards and deductions is not more than the QMB income limits, you can get QMB. See your county financial worker for information about these deductions. See table below.

QMB gross* income limits

April 1, 2001 - March 31, 2002

Family Size	Monthly Income
1	$ 736
2	988
3	1,240
4	1,491
5	1,743
6	1,995
7	2,246
8	2,750
Additional	272

Social Security gross income is your benefit* **before *premiums or other amounts are subtracted*

What are the QMB asset limits?

Assets are what you own including cash, savings, and non-homestead property. A person living alone may own $10,000 in assets. A married couple or family may own $18,000 in assets.

Some assets that do not count are:

- Homestead property,
- Mobile home used as your primary home,
- Prepaid burial fund up to $1500,
- Burial space items,
- One motor vehicle under certain conditions.

Other income and asset guidelines

If you live with your spouse, your spouse's income and assets also count even if your spouse does not want to apply for QMB. If you are under age 21 and living with your parents,

your parents' income and assets also count even if your parents do not want to apply for QMB. **If you have a disability and are between the ages of 18 and 21, your parents' income and assets do not count.**

If you are someone's stepchild, the income and assets of your stepparents do not count. The income and assets of a child do not count when deciding the eligibility of their parents or brothers and sisters.

For more information

The information above can help you decide if you wish to apply for QMB. ***It does not cover all of the program rules.*** Your county agency will need all the facts about your situation before they can determine if you are eligible.

Even if you are not sure whether or not you may be eligible, you should apply as soon as possible. You cannot receive QMB benefits earlier than the month following the month that you apply.

For more information about MA, **contact your county human services agency or call Senior LinkAge Line ® at 1-800-333-2433.** You can check out our website at: www.dhs.state.mn.us/infocenter or www.dhs.state.mn.us/hlthcare

DHS-3396 (5/01)

Important information for Medicare enrollees

Could you use an extra $600 each year?

Your Medicare premiums could be paid for you through special programs. If you qualify, your monthly **Social Security check would increase** by the amount you currently pay for premiums. The Medicare Part B premium is $50.00 a month.

Available benefits

If you qualify, there are programs that will:

- Pay Part A and B Medicare premiums, deductibles and copayments

or

- Pay Part B Medicare premiums only

or

- Reimburse you for a small part of your Part B Medicare premium.

If you are 65 and a resident of Minnesota for six months or more, you may also be eligible for the Minnesota Prescription Drug Program which helps you pay for your prescription drugs. *You pay the first $35 a month and the program pays the rest!*

How to qualify

You may be eligible for one or more of these programs if:

- You are single, your gross income is $1,253 or less a month and your assets (not counting your home or car) are $10,000 or less

or

- You are married, your gross income is $1,694 or less a month and your assets (not counting your home or car) are $18,000 or less.

For more information

Find out if you qualify for these programs by calling:

Senior LinkAge Line®
1-800-333-2433

Or visit your local county social or human service center. You can also find information about these programs on the internet: *http://www.hcfa.gov/medicaid/obs4.htm*

There are other health care programs available. To find out about additional programs, call the Senior LinkAge Line®.

This information is available in other forms to people with disabilities by contacting us at 651-296-8517 (voice), toll free at 1-800-657-3659, or through the Minnesota Relay Service at 1-800-627-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay service).

Minnesota Department of **Human Services**

Are you on Medicare, but still having a hard time paying for drugs or medical bills?

Come to the Benefits Outreach to see if you qualify for programs that save you money.

July 31 9-11 am	Red Wing Wells Fargo Bank
July 31 1-3 pm	Zumbrota Public Library
Aug. 1 9-11 am	Kenyon Adult Center
Aug 1 1-3 pm	Cannon Falls - Stone House Apts.
Aug. 3 9-11 am	Pine Island St. Michael's Catholic Church

Call the Senior LinkAge Line® 1-800-333-2433 for more information.

Sponsors:
- *SE MN Area Agency on Aging
- *Goodhue County Social Services
- *Social Security Administration
- *So. MN Regional Legal Services
- *Three Rivers Community Action

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Sponsors:
- *SE MN Area Agency on Aging
- *Goodhue County Social Services
- *Social Security Administration
- *So. MN Regional Legal Services
- *Three Rivers Community Action

If your monthly gross income is less than $879 for 1 person or $1181 for 2 people, and, your assets (not including your home or a car) are less than $10,000 for one person or $18,000 for two, you may qualify for a Medicare Savings Program that will pay your Medicare premium!

If you are age 65 or older and have no health insurance that pays for prescription drugs, you may qualify for Minnesota's Prescription Drug Program. On the drug program you pay the first $35 a month toward your drugs and the state pays the rest!

Applications are available at your county social services department or through the Benefits Outreach, or call the

Senior LinkAge Line® 1-800-333-2433.

SE MN Area Agency on Aging, Inc.
421 SW First Ave., Suite 201, Rochester, MN 5590
Phone:507-288-6944
Fax: 505-288-4823
Email: semaaa@semaaarochestermn.org

If your monthly gross income is less than $879 for 1 person or $1181 for 2 people, and, your assets (not including your home or a car) are less than $10,000 for one person or $18,000 for two, you may qualify for a Medicare Savings Program that will pay your Medicare premium!

If you are age 65 or older and have no health insurance that pays for prescription drugs, you may qualify for Minnesota's Prescription Drug Program. On the drug program you pay the first $35 a month toward your drugs and the state pays the rest!

Applications are available at your county social services department or through the Benefits Outreach, or call the

Senior LinkAge Line® 1-800-333-2433.

SE MN Area Agency on Aging, Inc.
421 SW First Ave., Suite 201, Rochester, MN 5590
Phone:507-288-6944
Fax: 505-288-4823

Minnesota

Tables and Figures

Table D-1

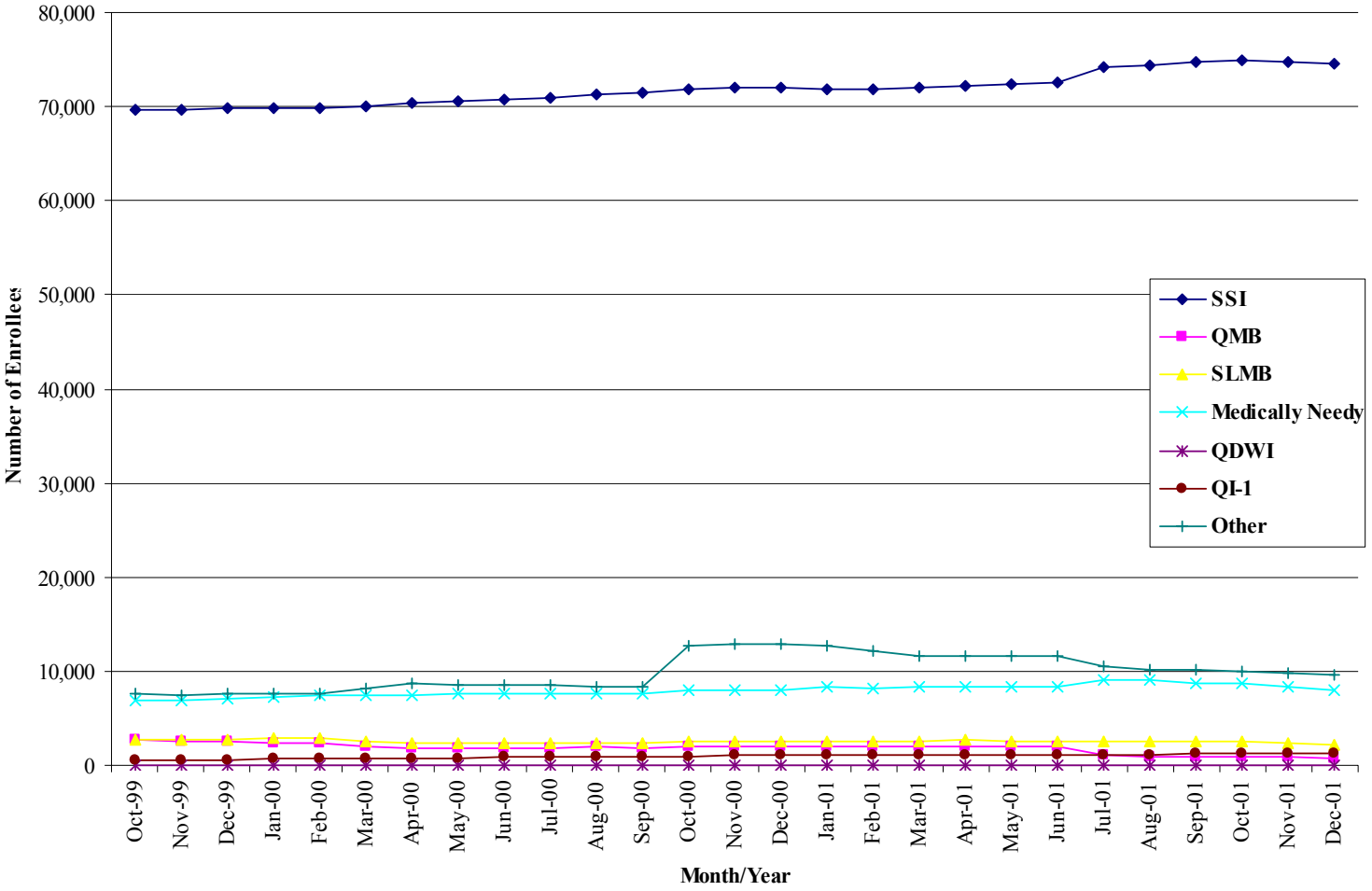
Minnesota: Percent Change in Person-Years of Enrollment Between Baseline and Grant Periods by Region in the Demonstration Area

	Region 1	Region 7W	Region 10
	%	%	%
# of Person-Years	8.3	16.1	10.6
Age			
<65	9.3	20.6	14.9
65-74	11.1	19.9	20.3
75-84	22.5	22.2	12.7
85+	-7.1	2.6	-5.5
Gender			
Male	8.0	17.5	9.9
Female	9.0	13.5	12.2
Race			
White	2.5	12.7	9.4
Black	23.8	2.4	3.0
Asian/Pacific Islander	39.1	-53.3	13.7
Native American	0.0	21.3	10.7
Other	153.6	91.7	44.6
Program Eligibility			
SSI	2.3	6.2	3.5
QMB	-31.3	-24.5	33.7
SLMB	-3.2	4.1	-12.7
Medically Needy	8.9	47.7	24.6
QI-1	58.2	37.8	20.4
Other	71.0	87.3	64.8

SOURCE: HER analysis of Minnesota Medicaid Eligibility Data, October 1999-December 2001.

Figure D-2

Minnesota: Number of Enrollees by program Eligibility and Month
(October 1999 - December 2001)



APPENDIX E

MONTANA

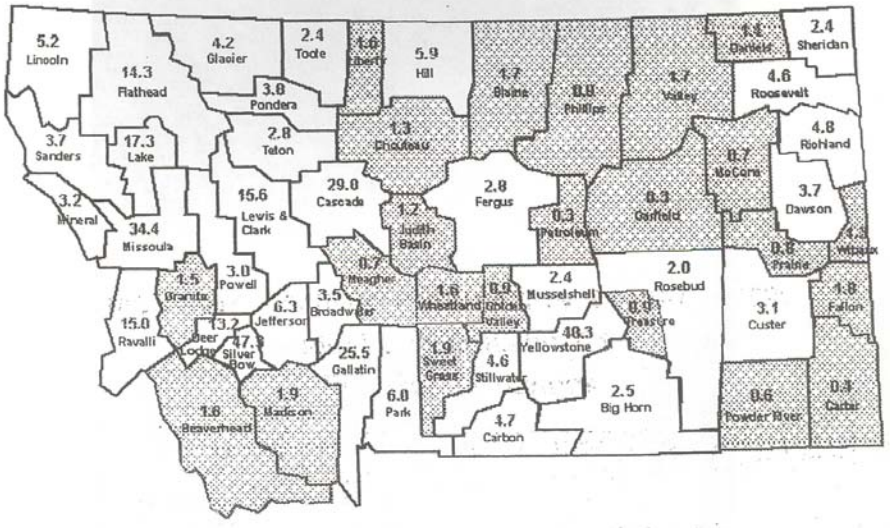
Map of Montana

Figure E-1

MONTANA COUNTY POPULATION DENSITY - 1999

Montana's Density: 6.1

"Frontier*" Counties



* Frontier refers to a 19th century Census Bureau standard of an area west of the 99th meridian with fewer than 2 persons per square mile.

Source: U.S. Bureau of the Census
Graphics by: Census and Economic Information Center, MT Dept. of Commerce

Montana

Enrollment Application and Outreach Materials

What if I need regular Medicaid coverage or Food Stamps?

You should call the local office of public assistance and request an application for those programs. The information you provide on this form is only enough for us to decide if you qualify for a Medicare Savings Program.

What are my rights?

All programs administerd by Montana's Department of Public Health and Human Services are equal opportunity programs. You cannot be treated differently because of your race, color, sex, age, disability, religion, nationality or political beliefs. If you believe you have been discriminated against, you may file a complaint with either the Regional Manager, Region III Office of Civil Rights, 1961 Stout St. Room 1185 FOB, Denver, CO 80294-3538 or with the Director, Office of Civil Rights, US Dept. Of Health and Human Services, 330 Independence Avenue SW, Washington DC 202951.

If you believe the decision made on your application is incorrect, you may ask for a Fair Hearing by completing the Fair Hearing request form on the back of your notification letter, or by writing directly to DPHHS/Quality Assurance Division, Office of Fair Hearings, PO Box 202953, Helena, MT 59620.

20,000 copies of this public document were published at an estimated cost of $.028 per copy, for a total cost of $560.00, which includes $560.00 for printing and $.00 for distribution.

DPHHS-HCS-004A
(New 4/00)
State of Montana
Department of Public Health and Human Services

Medicare Savings for Qualified Beneficiaries

You may qualify for help with:

- Medicare Premiums
- Medicare Deductibles
- Medicare Coinsurance

HELP US share information about these programs! If you don't use the form, please pass it on to someone who can.

If you have or qualify for Medicare, help may be available to pay some or all Medicare expenses for you. Those who may qualify:

* **Are age 65 or older or disabled,**
* **Are Montana residents,**
* **Have a Social Security Number, and**
* **Meet income and resource guidelines.**

These Medicare Savings Programs are:

- QMB - Qualified Medicare Beneficiary Program. Program benefits include payment of Medicare premiums, deductibles and coinsurance payments.
- SLMB - Special Low Income Medicare Beneficiary. This program benefit is payment of Medicare premiums.
- QI-1 - Qualifying Individual-1. This program benefit is payment of Medicare premiums.
- QI-2 - Qualifying Individual-2. This program benefit is annual reimbursement to you of a portion of your Medicare premium...for 2000, the maximum reimbursement is $34.32 per year.

How To Apply:

1. Remove and complete the attached application form.
2. Sign the application.
3. Attach copies of documentation.
4. Mail the application to your local county office of public assistance.

An interview is not required for these programs. If more information is needed, the local county office of public assistance will contact you.

Where can I call for help?

If you need help completing this form, you may call the county office of public assistance. They may assist you, or they may refer you to a volunteer for assistance. You may also have anyone of your choosing assist you in completing the form.

How do I know if I qualified once I apply?

The office of public assistance will notify you in writing of the results of your application. If you qualify, you will be notified of the date your coverage will begin. All applications are to be processed within 45 days.

DPHHS-HCS-004AA
(New 4/00)

State of Montana
Department of Public Health and Human Services

Montana Application for Medicare Savings Programs

NOTE: This is only an application for Medicare Savings. If you want to apply for food stamps, cash assistance or regular, full Medicaid coverage, contact your local county office of public assistance.

1. INSTRUCTIONS:

Read the application carefully and follow all instructions given throughout the form.

1. Answer each question completely and accurately. Attach additional pages if needed.
2. Include copies of all documentation (requested information) including citizenship.
3. **Sign the application.**
4. Mail the application to your local public assistance office.
5. An interview is not required for these programs.
6. If you have children living with you, it is suggested that you use application form DPHHS-FA-250 for a more accurate determination of eligibility.

AGENCY USE ONLY
Case No. _____
Date Received _____
Worker _____

2. PERSONAL INFORMATION: (Applicant)

Name (Last, First, Middle Initial)
Birthdate Sex Race Marital Status
Social Security Number U.S. Citizen ❒Yes ❒No
Street Address
Mailing Address (if not Street Address)
City State Zip
Phone County

3. INFORMATION ON SPOUSE (Even if not applying for spouse)

Name (Last, First, Middle Initial)
Birthdate Sex Race
Social Security Number U.S. Citizen ❒Yes ❒No
Street Address (if different from applicant)
City State Zip
Phone County
Are you applying for Medicare savings for your spouse, too? ❒Yes ❒No

You may have someone else help you complete this application. If someone other than applicant or spouse is completing this form, provide the following information for the individual completing the form.

Name (Last, First, Middle Initial) Relationship to Applicant
Street Address City State Zip
Daytime Phone

4. LIVING ARRANGEMENT: Check the one box that describes current living situation.

	In Own Home	Renting	Nursing Facility	In Other's Home	Other (example: shelter)	Amount of Rent or Mortgage
Self			Date Admitted:		Describe:	
Spouse			Date Admitted:		Describe:	

Provide proof of your housing costs such as a rent receipt, mortgage bill or house tax notice.

5. INFORMATION ON MEDICARE:

Attach copies (front and back) of Medicare card(s) if you, or your spouse, have Medicare.

Do you have Medicare? ❒Yes ❒No	If Yes, Type of Coverage ❒ Part A ❒ Part B ❒ Both	Effective Date	Medicare ID Number
Does your spouse have Medicare? ❒Yes ❒No	If Yes, Type of Coverage ❒ Part A ❒ Part B ❒ Both	Effective Date	Medicare ID Number

6. INFORMATION ON OTHER INSURANCE:

Do you have other health insurance? **❒Yes ❒No**

Does your spouse have other health insurance? **❒Yes ❒No**

If you or your spouse have other insurance, please provide the following information and attach a copy (front and back) of insurance card(s):

	Health Insurance Company Name and Company Address	Premium Amount	Type of Coverage (Hospital, Medigap, RX)	Effective Date	ID Number
Self		$ Per _____ (mo., qtr)			
Spouse		$ Per _____ (mo., qtr)			

7. PROPERTY:

Do you own all or part of any real estate, including your home? **❒Yes ❒No**

If yes, please provide the following for each piece of real estate and attach proof of ownership and current value.

Address	Value	Amount Owed

Do you, or your spouse, own a car, truck, motorcycle, boat, trailer, or other vehicle? **❒Yes ❒No**

If yes, please provide the following information about each vehicle, and attach a copy of each title or registration:

Owner(s)	Year	Make	Model	Value	Amount Owed

8. RESOURCES:

Check all resources (assets) owned by you and/or your spouse. Include any accounts or properties on which you and/or your spouse's name(s) appear. Provide verification of the value (past 3 bank statements, trust fund documents, etc.) of all resources.

Do you, or your spouse, have any of the following?					
Checking account	❒Yes	❒No	Funeral plans/ burial contracts/plots	❒Yes	❒No
Savings account	❒Yes	❒No	Certificates of Deposit	❒Yes	❒No
Stocks/Bonds	❒Yes	❒No	Contracts for Deed	❒Yes	❒No
Trust funds	❒Yes	❒No	Other (items of unusual value, retirement account, etc.)	❒Yes	❒No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Investment or Insurance Company, Etc.

9. LIFE INSURANCE: Do you, or your spouse, have life insurance? ❒Yes ❒No

If yes, please provide the following information and attach a copy of the policy:

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

10. INCOME AND EARNINGS:

List all types of income that you and/or your spouse receive. List the income amount before deductions (such as taxes or insurance) are taken out. Include proof of all income (check stubs, benefit letter, etc.). Examples of income include:

* Social Security
* SSI
* Wages/ Self-Employment
* Railroad Retirement Benefits
* Veterans' Benefits
* Trust or Annuity Payments
* Pensions/ Retirement Benefits
* Rental Income
* Oil Royalties/ Mineral Rights
* Contract for Deed Payments

Who Receives Income (Name)?	Type of Income	Employer or Source of Income	Amount	How Often Received?	ID Number (if applicable)

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party that may be liable to pay for care and services. I understand that I must report any settlement received for medical care within ten days.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that changes in my circumstances, such as a change in income, must be reported to this agency within ten days.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. If I feel I have been discriminated against, I may file a complaint with either the Regional Manager, Region III Office of Civil Rights, 1961 Stout St. Room 1185 FOB, Denver, CO 80294-3538 or with the Director, Office of Civil Rights, US Dept. of Health and Human Services, 330 Independence Avenue SW, Washington DC 202951. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse:	**Date:**

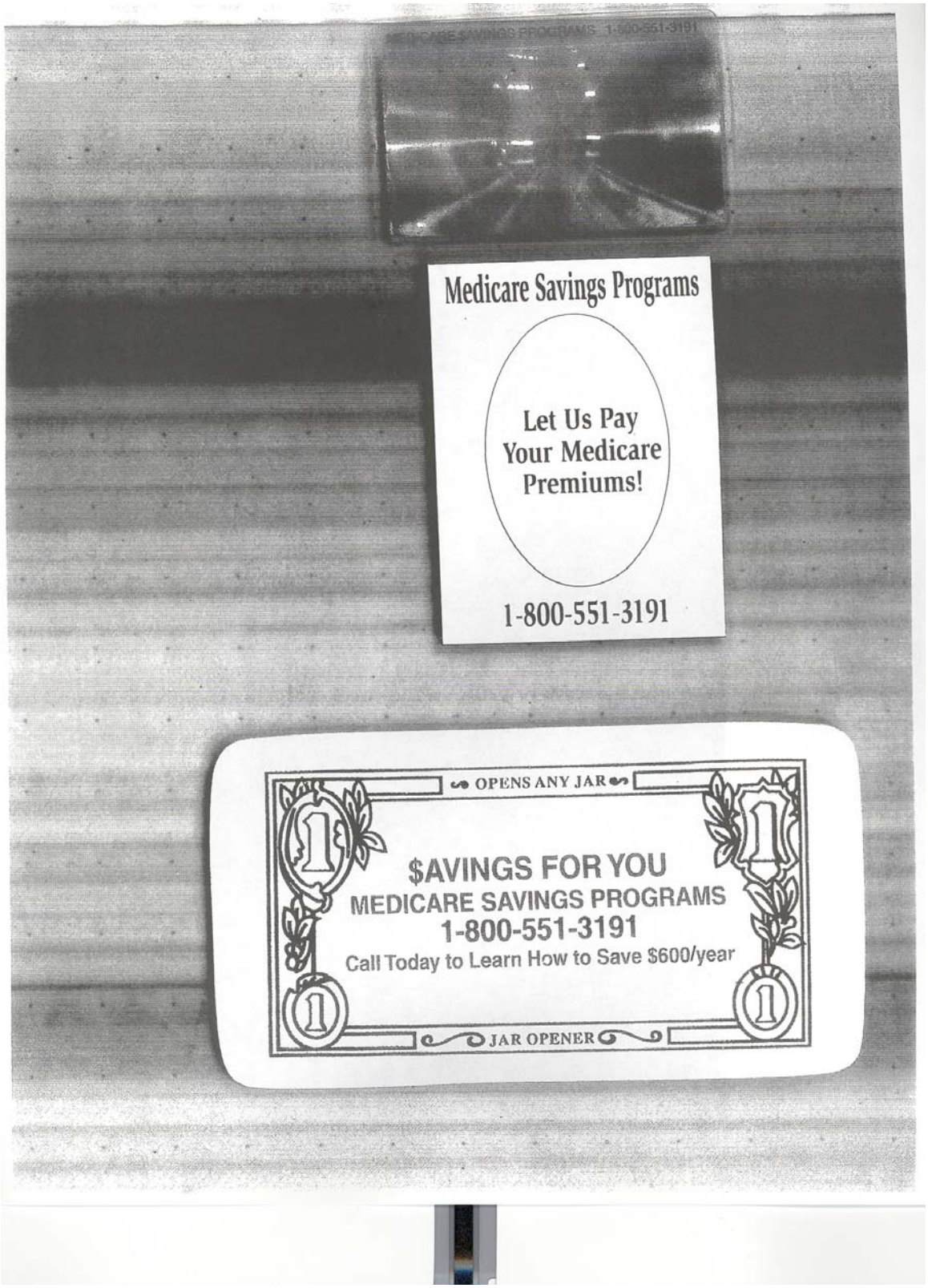
DPHHS-HCS-004B
(Rev 5/01)

State of Montana
Deparatment of Public Health and Human Services

Income and Resource Guidelines
May 2001 - April 2002

	Resource Limits	QMB Income Limits	SLMB Income Limits	QI-1 Income Limits	QI-2 Income Limits
Single Individual	$4000	$716	$859	$967	$1253
Couple	$6000	$968	$1161	$1307	$1694

QMB is the Qualified Medicare Beneficiary Program
SLMB is the Special Low-Income Medicare Beneficiary Program
QI-1 and QI-2 are Qualifying Individuals Programs..

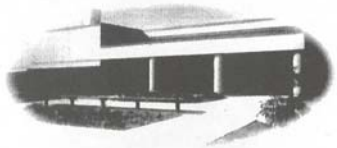

Medicare Savings Programs
Let Us Pay Your Medicare Premiums!
1-800-551-3191
OPENS ANY JAR
$AVINGS FOR YOU
MEDICARE SAVINGS PROGRAMS
1-800-551-3191
Call Today to Learn How to Save $600/year
JAR OPENER

What is Medicare?

- Medicare is a federal health insurance program for people 65 years of age or older
- Medicare can also provide health services for young people with disabilities.

For more information, call 1-800-551-3191 and ask for the Medicare Savings Program.

What does Medicare Part A cover?



In-Patient Hospital Health Care

Out-Patient Hospital Health Care

In-Patient Nursing Home Care

In-Patient / Out-Patient Follow-up Health Care

For more information, call 1-800-551-3191 and ask for the Medicare Savings Program.

What does Medicare Part B cover?

Physician Services

Out-Patient
Home Health Care

Physician's Assistants
and Chiropractors

Ambulance Service

In-Home Durable
Medical Equipment

Laboratory Blood Work

For more information, call 1-800-551-3191 and ask for the Medicare Savings Program.

MEDICARE PROGRAMS

Important Reasons Why People Need to Apply:

- You will have expanded options for health care services.
- If you are Native American, you will be able to receive health care from specialists not available from the Indian Health Service.
- You will be able to receive a better selection of medicines, medical equipment and supplies.
- You will be able to get quicker Emergency room services.
- You will be able to get 24 hour, 7 days a week, in/out of state health care services.
- If you are Native American, you will help assist the Indian Health Service in having medical dollars to serve other community members.

For more information, call 1-800-551-3191 and ask for the Medicare Savings Program.

MEDICARE PROGRAMS

How To Apply:

Step 1:
You may call 1-800-551-3191 or write for a Medicare Savings Program application form.

Step 2:
You may complete the application form and attach verification documents or you may request an appointment to receive assistance.

Step 3:
Mail your application packet to your local Office of Public Assistance.

Within 45 days, you will receive a letter from your local Office of Public Assistance. They will approve, deny, or request additional information.

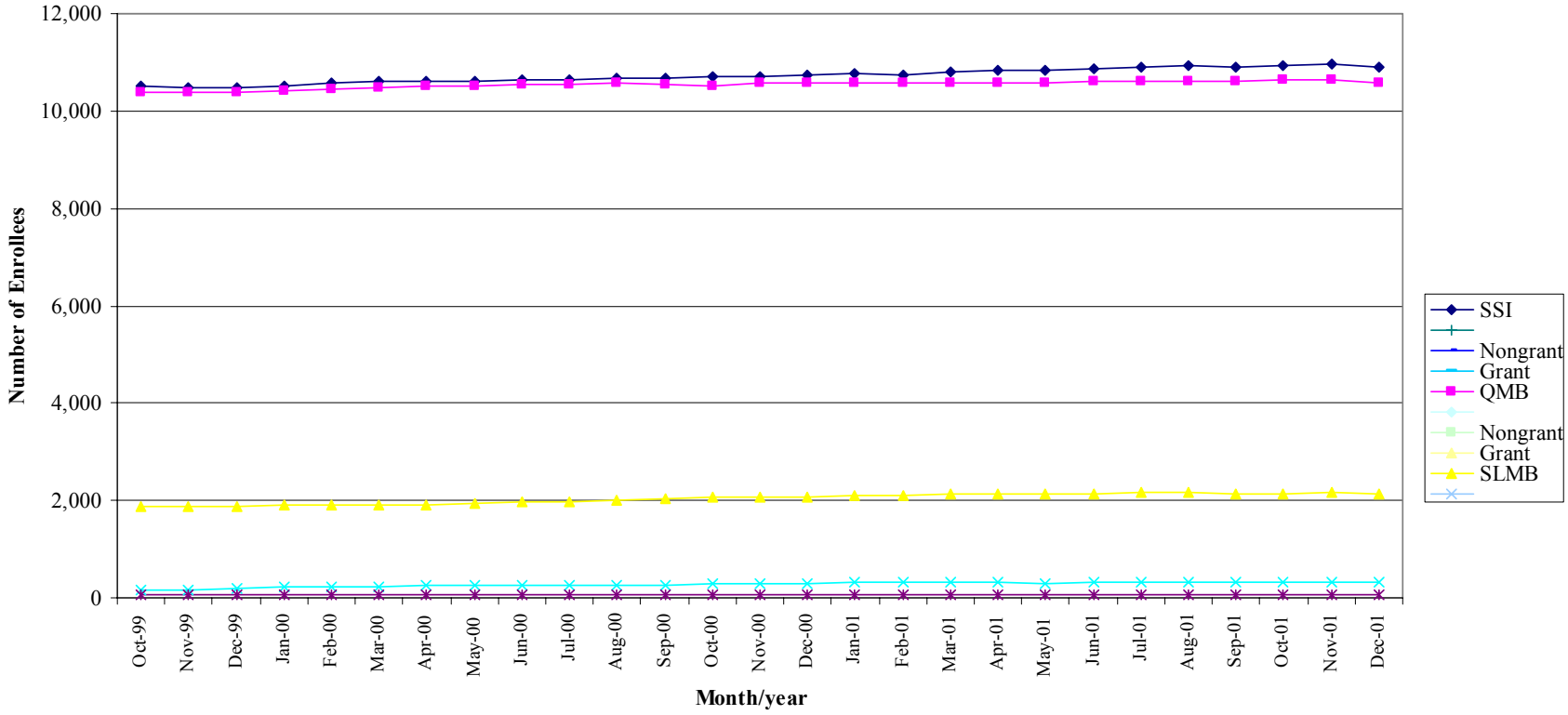
For more information, call 1-800-551-3191 and ask for the Medicare Savings Program.

Montana

Tables and Figures

Figure E-2

Montana: Number of Enrollees by Program Eligiblity and Month
(October 1999 - December 2001)



APPENDIX F

TEXAS

Map of Texas

Figure F-1

Counties Listed by AAA Region

***Rio Grande*: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis and Presidio**

***Middle Rio Grande*: Dimmit, Edwards, Kinney, LaSalle, Maverick, Real, Uvalde Valverde, and Zavala**

***South Texas:* Jim Hogg, Starr, Webb and Zapata**

***Lower Rio Grande*: Camreon, Jidalgo and Willacy**

Texas

Enrollment Application and Outreach Materials

APPLICATION FOR ASSISTANCE – AGED AND DISABLED
SOLICITUD PARA ASISTENCIA/PERSONAS DE EDAD AVANZADA Y DISCAPACITADAS

If you need help paying your medical expenses, assistance with home care, or help paying Medicare cost-sharing expenses, the Texas Medicaid program may be able to help you. If you are interested, please complete the enclosed application.

It is important that you answer each question. Please enter "no" or "none" to questions that do not apply to you, and be sure that the application is signed and dated. You may ask a friend or relative to help you.

Please include with your application proof of all income and things that you own. The proof may be COPIES of the documents listed below; DO NOT SEND ORIGINALS:

- **Award letters (VA, Social Security, Railroad Retirement)**
- **Earnings statements**
- **Current bank statements**
- **Savings passbook**
- **Certificates of deposit**
- **Certificates of notes, stocks, or bonds**
- **Insurance policies (life, burial, or hospitalization)**
- **Transfer papers or deeds (for anything that you owned, but sold or gave away)**
- **Prepaid burial contracts**

After your application is received, we will review it to determine if you are eligible. We will notify you of the decision within 45 days.

Si necesita ayuda para pagar gastos médicos, servicios de atención médica en casa o su parte de los gastos de Medicare, es posible que el programa de Medicaid de Texas pueda ayudarle. Si está interesado, por favor, llene la solicitud adjunta.

Es importante que conteste todas las preguntas. Conteste "no" o "ninguno" a las preguntas que no aplican a su situación. Asegúrese de firmar la solicitud y poner la fecha. Puede pedir la ayuda de un pariente o amigo para contestar las preguntas.

Por favor, envíe con la solicitud comprobantes de todos sus ingresos y bienes. NO MANDE LOS ORIGINALES. Estos comprobantes deben ser COPIAS de:

- Cartas de concesión (para pensiones de veteranos, Seguro Social o ferrocarril)
- Estados de ingresos
- Estados de cuentas bancarias
- Libretas de cuentas de ahorros
- Certificados de depósito
- Certificados de notas, acciones o bonos
- Pólizas de seguro (vida, entierro u hospitalización)
- Documentos de traspaso o escrituras (de pertenencias o propiedades suyas que vendió o regaló)
- Contratos de entierro prepagados

Después de recibir la solicitud, la estudiaremos para ver si llena los requisitos de elegibilidad. Le avisaremos de la decisión, dentro de los 45 días.

IF YOU HAVE ANY QUESTIONS REGARDING THE APPLICATION,

PLEASE CALL:
LLAME AL:

SI TIENE ALGUNA PREGUNTA SOBRE LA SOLICITUD, POR FAVOR,

When you have completed the application, please mail it to us in the attached envelope. Someone will be in touch with you to schedule an inteview. An interview is required as part of the application process. You may request a telephone interview.

Free legal help from outside the department is available in many communities; call your local department office for information.

Al completar la solicitud, por favor, envíenosla en el sobre adjunto. Alguien le llamará para programar una entrevista. Se requiere la entrevista como parte del trámite de solicitud. Puede pedir una entrevista por teléfono.

En muchos lugares se pueden obtener servicios de abogado gratis. Estos servicios no son del departamento, pero la oficina local puede darle información.

- I have been advised and understand that this application or recertification will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief.
- I have been advised and understand that I may request a review of the decision made on my application or recertification for assistance and may request a fair hearing, orally or in writing, concerning any action or inaction affecting receipt or termination of assistance.
- If my case is selected for review, I give my consent for the Texas Department of Human Services (DHS) to obtain information from any source to verify the statements I have made.
- I understand that DHS uses my Social Security number to compare its records with records of other state and federal agencies, such as the Texas Workforce Commission, Internal Revenue Service, Bureau of Veterans Affairs, Social Security Administration, and others, to ensure that benefits are correctly determined.
- I certify that DHS has provided me with information about a range of long-term care services that are available in my area, as required by state law (1 Texas Administrative Code, Section 351.15).

PENALTY STATEMENT

- My answers to all of the questions, and the statements I have made, are true and correct to the best of my knowledge and belief.
- I understand that if I obtain, or assist another person in obtaining, medical assistance by fraudulent means, I may be charged with a state or federal offense; and I may also be held liable for any repayment of benefits fraudulently obtained.
- I will let DHS know, within 10 days, of any changes that could affect my eligibility. This includes changes in income, resources, living arrangement, property holdings, or insurance (including health insurance premiums).

- Me avisaron y comprendo que esta solicitud o esta nueva certificación se estudiará sin discriminación de raza, color, religión, creencias, origen nacional, edad, sexo, discapacidad o creencias politicas.
- Me han avisado y comprendo que puedo pedir una revisión de la decisión que se tome sobre la solicitud o nueva certificación para asistencia, y que purdo pedir, oralmente o por escrito, una audiencia imparcial con respecto a cualquier acción, o falta de acción que afecte la concesión o la terminación de asistencia.
- Si escogen mi caso para una revisión, doy permiso que el Departamento de Servicios Humanos de Texas (DHS) obtenga información de cualquier fuente para verificar las declaraciones que he hecho.
- Comprendo que para asegurar una determinación correcta de los beneficios, el DHS usa mi número de Seguro Social para comparar sus archivos con los archivos de otras agencias estatales y federales, por ejemplo, la Comisión de la Fuerza Laboral de Texas, el Servicio de Impuestos Internos, la Oficina de Asuntos del Veterano y la Administración del Seguro Social.
- Certifico que DHS me dio información sobre varios servicios de atención a largo plazo que se pueden conseguir en mi región, de conformidad con la ley estatal (1 *Texas Administrative Code, Section* 351.15).

DECLARACIÓN DE SANCIONES

- Mis respuestas a todas las preguntas anteriores y las declaraciones que he hecho son verdaderas y correctas a mi leal saber y entender.
- Comprendo que si obtengo, o ayudo a otra persona a obtener, fraudulentamente asistencia médica, me pueden acusar de una ofensa federal o estatal; y pueden hallarme responsible de la devolución de beneficios obtenidos fraudulentamente.
- Avisaré al DHS cualquier cambio que pudiera afectar mi elegibilidad dentro de los 10 dias siguientes al cambio. Éstos pueden ser, entre otros, cambios en: ingresos, recursos, arreglos de vivienda, propiedades o seguros (inclusive en las primas de seguros médicos).

List ALL resources owned by You or Your Spouse. (Some resources may not be counted.)
Indique TODOS los recursos que le pertenecen a usted o a su cónyuge. (Puede que algunos recursos no se cuenten).

Type Tipo	Amount Cantidad	Source/Name/Account No. Fuente/Nombre/Núm. de ciemta
Checking Account Cuenta de cheques	$	
Savings Account Cuenta de Ahorros	$	
Certificate of Deposit Certificado de depósito	$	
Stocks/Bonds/Annuities Acciones/Bonos/Anualidades	$	
Preneed Funeral Contract Contrato de entierro prepagado	$	
Cash on Hand Dinero en efectivo	$	
Notes Pagarés	$	
Automobiles Automóviles	$	
Life Insurance Seguro de vida	$	
Burial Insurance Seguro de entierro	$	
Burial Plots Terremps de sepultura	$	
Other Lots of Land Otros terrenos o tierras	$	
Additional Resources Owned by You or Your Spouse Recursos adicionales que le pertenecen a usted o a su cónyuge	$	
	$	
	$	

HEALTH/HOSPITALIZATION INSURANCE/SEGURO MÉDICP/DE HOSPITALIZACIÓN

Are you now covered or have you been covered during the past year by any insurance (no Medicaid or Medicare) paid for by you or someone else?
¿Tiene, o tuvo durante el año pasado, cobertura de algún seguro médico (que no sea Medicaid o Medicare) que usted u otra persona pagó? . . . . . ☐ Yes/Sí ☐ No

If "Yes," complete the following: /Si contesta "Sí", llene lo siguiente:

Name of Insurance Company /Nombre de la compañía de siguiente:	**Policy No.**/Núm. de póliza
Address of Insurance Company/Dirección de la compañía de seguros	**Beginning Coverage Date** Fecha de vigencia de la cobertura

Texas Department
of Human Services

Form 1200EZ
September 2000

If form is being distributed by an agency other than Texas Department of Human Services, enter agency name:

For DHS use only		Date Form Requested	Date Form Mailed	BJN
	☐ Application			
	☐ Recertification	Date Form Received	Appointment Date	Applicant/Client No.

APPLICATION FOR ASSISTANCE–AGED AND DISABLED
SOLICITUD PARA ASISTENCIA/PERSONAS DE EDAD AVANZADA O DISCAPACITADA

Applicant's name (last, first, middle initial) Nombre del solicitante (apellido, nombre, inicial)			Social Security No. Núm. de Seguro Social	Medicare Claim No. Núm. de reclamación de Medicare
Home Address Domicilio	City, State, ZIP Ciudad, Estado, ZIP	County Condado	Telephone No. Núm. de teléfono	
Date of Birth Fecha de nacimiento	Sex Sexo	Race Raza	U.S. Citizen? ¿Es ciudadano de EE.UU. ☐Yes/Sí ☐No	Resident of Texas? ¿Es residente de Texas? ☐Yes/Sí ☐No
Spouse's name (last, first, middle initial) Nombre del solicitante (apellido, nombre, inicial)			Social Security No. Núm. de Seguro Social	Medicare Claim No. Núm. de reclamación de Medicare
Spouse's Address (if different) Domicilio	City, State, ZIP Ciudad, Estado, ZIP	County Condado	Telephone No. Núm. de teléfono	
Date of Birth Fecha de nacimiento	Sex Sexo	Race Raza	U.S. Citizen? ¿Es ciudadano de EE.UU. ☐Yes/Sí ☐No	Resident of Texas? ¿Es residente de Texas? ☐Yes/Sí ☐No

Where do you live?/¿Dónde Vive?

- ☐ **Own home** / Vivo en casa propia
- ☐ **Rent House/Apartment** / Alquilo casa/apartamento
- ☐ **Live in House Provided by Someone** / Vivo en casa de otra persona
- ☐ **Live with Someone** / Vivo con alguien
- ☐ **Nursing Facility** / Vivo en casa para convalecientes

Do you pay rent?/¿Paga renta? .... ☐Yes/Sí ☐No

Do you pay for your own food?/ ¿Paga por su propia comida? ..... ☐Yes/Sí ☐No

Do you have Medicare Part A? ¿Tiene Medicare Parte A? ..... ☐Yes/Sí ☐No

Does your spouse have Medicare Part A? ¿Tiene su cónyuge Medicare Parte A? ..... ☐Yes/Sí ☐No

Do you have Medicare Part B? ¿Tiene Medicare Parte B? ..... ☐Yes/Sí ☐No

Does your spouse have Medicare Part B? ¿Tiene su cónyuge Medicare Parte B? ..... ☐Yes/Sí ☐No

List ALL Income Available to You or Your Spouse. (Some incomes may not be counted.)
Indique TODOS los ingresos que usted y su cónyuge tienen a su disposición. (Puede que algunos ingresos no se cuenten).

	APPLICANT/CLIENT / SOLICITANTE/CLIENTE		SPOUSE / CÓNYUGE	
TYPE OF INCOME TIPO DE INGRESOS	**Monthly Gross** Ingreso Mensual Bruto	**Source** Fuente	**Monthly Gross** Ingreso Mensual Bruto	**Source** Fuente
Social Security Seguro Social	$		$	
VA Pension Pensión de la VA	$		$	
Wages Sueldos	$		$	
RR Retirement Pensión de Ferrocarril	$		$	
Civil Service Servicio Civil	$		$	
Pension Pensión	$		$	
Annuity Anualidad	$		$	
Interest Interés	$		$	
Farm Income Ingresos agrícolas	$		$	
Mineral/Royalty Derechos minerales /Regalías	$		$	
Gifts Regalos	$		$	
Other Income Otros Ingresos	$		$	

Signature–Applicant/Client Firma–Solicitante/Cliente _____ **Date** Fecha _____ **Signature–Spouse** Firma–Cónyuge _____ **Date** Fecha _____

If the Applicant/Client cannot sign his/her name, two witnesses to the applicant making his mark (X) must sign below:
Si el solicitante/cliente no puede firmar su nombre, dos testigos deben estar presentes cuando el solicitante/cliente escriba una (X) y ellos deben firmar a continuación:

Signature–Witness Firma–Testigo _____ **Date** Fecha _____ **Signature–Witness** Firma–Testigo _____ **Date** Fecha _____

Signature–Responsible Party Firma–Persona Responsable _____ **Date** Fecha _____

Name of Person Completing Form (if not applicant/client) Nombre de la persona que completa el formulario (si no es el solicitante/cliente)	**Relationship to Applicant/Client** Relación con el solicitante/cliente	**Telephone (home)**/Teléfono (casa)
Address (Street, City, State, ZIP)/Dirección (Calle, Ciudad, Estado ZIP)		**Telephone (work)**/Teléfono (trabajo)

- **If you believe you have been discriminated against because of race, color, national origin, age, sex, disability, political beliefs, or religion, you may lodge a complaint with the management staff of this agency and/or write or call immediately to:**

Civil Rights Department
Texas Department of Human Services
P.O. Box 149030
Austin, TX 78714-9030
512/438-4313
TDD: 512/438-2960

or to:
o a:

U.S. Dept. of Health and Human Services
Office of Civil Rights – Region VI
1301 Young St., Room 1169
Dallas, TX 75202
1/800/368-1019
TDD: 1/214/767-8940

- Si usted cree que lo han discriminado por motivo de raza, color, origen nacional, edad, sexo, discapacidad, creencias políticas o religión, puede presentar una queja ante la administración de esta agencia o escribir o llamar inmediatamente a:

El Paso

TEXAS LEGAL SERVICES CENTER

SUMMARY OF CERTAIN BENEFIT PROGRAMS APRIL 1, 2001 THROUGH MARCH 31, 2002

Program	Gross Monthly Income Limit		Countable Resource Limit	
	Individual	*Couple*	*Individual*	*Couple*
Supplemental Security Income (SSI)	$550	$816	$2000	$3000
QMB	$736	$988	$4000	$6000
SLMB	$879	$1181	$4000	$6000
QI-1	$987	$1327	$4000	$6000
QI-2	$1273	$1714	$4000	$6000
QDWI	$1452	$1955	$4000	$6000
Long-term care Medicaid	$1590	$3180	$2000	$3000

To Qualify:

- **Income** must be *below* the figures shown for SSI, QI-1, and QI-2. Income can be equal to or less than the figure shown for QMB, SLMB, and long-term care Medicaid. *Twenty dollars ($20) is automatically deducted from the figures given above* (except for long-term care Medicaid). Also, for QMB, SLMB, QI-1, and QI-2, the first $65 of monthly earned income (wages or salary), and one-half the remainder is deducted before the $20 is taken out, to calculate *countable earned income*.
- **Resources:** The following items are not counted: The homestead lived in by the applicant or the applicant's spouse regardless of size or value (an Intent to Return Home, DHS Form 1245, will also exclude the homestead); one vehicle used to get to work or needed to get to medical care (if not, exclude the first $4500 in value); household possessions and clothing; $1500 face value whole life insurance; burial items already paid for (plot, casket, grave markers), and some other items.

Benefits:

- **SSI:** Monthly cash payment for persons who are at least 65 years old or disabled or blind – pays $1 for every $1 below the income limit and provides regular Medicaid;
- **QMB:** Payment of all Medicare premiums, co-insurance, and deductibles;
- **SLMB:** Payment of the Medicare Part B premium ($50.00 in 2001);
- **QI-1:** Payment of the Medicare Part B premium ($50.00 in 2001);
- **QI-2:** Payment of that part of the Medicare Part B premium that pays for home health costs;
- **Long-term care Medicaid:** Nursing home or community-based (in-home) nursing care and related services.

Where to apply: For SSI call Social Security (1-800-772-1213, TTY 1-800-325-0778). For all other programs call **1-888-834-7406** for an application from the Texas Department of Human Services, which administers all Medicaid programs. For more help with Medicare questions, call **1-800-252-9240**, TDD 1-800-252-9108. Persons who have disabilities can call **1-800-252-9108** (voice/TDD).

When do the limits change? SSI and Long-Term Care change on January 1st. The others, on April 1st.

Useful legal cites (TX): Cost-free medical records, for applications based on disability: Health and Safety Code, §161.201-204. Consent to Medical Treatment Act: Health and Safety Code, §313.001-007.

815 Brazos, Suite 1100 Austin, Texas 78701

(512) 477-6000 Fax: (512) 477-6576 web: www.tlsc.org

El Paso

TEXAS LEGAL SERVICES CENTER

RESUMEN DE ALGUNOS PROGRAMAS DE BENEFICIO
ABRIL 1, 2001 A MARZO 31, 2002

Programa	Límite de ingreso mensual		Límite de bienes contables	
	Individual	*pareja*	*individual*	*pareja*
Ingreso de Seguro suplementario (SSI)	$550	$816	$2000	$3000
QMB	$736	$988	$4000	$6000
SLMB	$879	$1181	$4000	$6000
QI-1	$987	$1327	$4000	$6000
QI-2	$1273	$1714	$4000	$6000
QDWI	$1452	$1955	$4000	$6000
Medicaid para cuidado a largo plazo	$1590	$3180	$2000	$3000

Para ser aceptado:

Ingreso. Debe ser menor a la cantidad del SSI, QI-1 y QI-2. El ingreso debe ser menor o igual a la cantidad del QMB, SLMB y Medicaid para cuidado a largo plazo. Se deducen veinte dólares ($20) automaticamente de las cifras de arriba (excepto para el Medicaid de cuidado a largo plazo). Para calcular el *ingreso ganado contable*, primero se deducen del QMB, SLMB, QI-1 y QI-2, $65 del ingreso mensual (pagos o salario), la cantidad sobrante se divide entre dos y se cuenta sólo una mitad para deducir los $20.

Bienes contables. No se incluye los siguientes: la residencia en donde el solicitante vive o en donde vive la esposa del solicitante sin importar el tamaño o valor (la forma DHS 1245 -Intent to Return Home-, queda excluída como residencia); un vehículo utilizado para llegar al trabajo o para transportarse al servicio médico (si no existe, se excluye el valor de $4500); posesiones en la casa o ropa; $1500 del valor del seguro de vida; artículos pagados para entierros (féretro, cementerio, placa en la tumba), y algunos otros artículos.

Beneficios:

SSI : Pago mensual en efectivo para personas que tienen por lo menos 65 años de edad, personas incapacitadas o ciegas — se paga $1 por cada $1 que se reciba abajo del límite de ingreso y se proporciona Medicaid regular;
QMB : Pago de todo las primas del Medicare, co-seguro y deducibles;
SLMB : Pago de la parte B de la prima del Medicare ($50.00 en 2001);
QI-1 : Pago de la parte B de la prima del Medicare ($50.00 en 2001);
QI-2 : Pago de la parte B de la prima del Medicare que cubre gastos para cuidado de la salud en casa;
Medicaid para cuidado a largo plazo: casa de asilo o cuidado comunitario (en casa) y servicios relacionados a éste.

Donde solicitar estos servicios: Para el SSI llama al Seguro Social 1-800-772-1213, TTY 1-800-325-0778. Para todos los demás programas llama al 1-888-834-7406 para solicitar una forma del Texas Department of Human Services, el cual administra todos los programas Medicaid. Para asistencia o preguntas sobre el Medicare, llama al 1-800-252-9240, TDD 1-800-252-9108. Personas incapacitadas pueden llama al 1-800-252-9108 (voice/TDD).

¿Cuándo cambian los límites?: SSI y cuidado a largo plazo cambian el día primero de enero. Todos los demás cambian el día primero de abril.

Notas legales de ayuda (TX): para solicitar formas basadas en la incapacidad, registros médicos libres de costo: Health and Safety Code, 161.201-204. Decreto para el consentimiento a tratamiento médico: Health and Safety Code, 313.001-007.

Laredo

Area Agency on Aging OF THE

SOUTH TEXAS DEVELOPMENT COUNCIL

SAVING FOR MEDICARE BENEFICIARS

"Getting the Most out of Medicare" is a nationwide effort to help

millions of people with Medicare save up to $600 a year on health care cost.
Ask for the QMB program that can pay your Medicare Part A premiums and save you a lot of money.
These programs may save you from $26.00 up to $600 in your Social Security money each year.

For information on :
Programs that save money for people with Medicare with Part A.
Who qualifies !
The benefits of the program.
How to apply, please call us.
We will assist you in completing the application.

For more information on how you can save on your Social Security Benefits, please call South Texas Development Council, Area Agency on Aging, Juan G. Sanchez (956)722-3995 or 1-800-292-5426.

AHORROS A BENIFICIARIOS DE MEDICARE

"Getting the Most out of Medicare"es un esfuerso a nivel nacional para ayudar a millones de personas en Medicare a ahorrase hasta $600 por ano en el costo del programa de Health Care de Medicare.
El programa QMB puede pagarle la prima de Medicare y ahorrarle bastante dinero.
Se pueden ahorrar desde $26.00 hasta $600 en sus cheques del Seguro Social por ano.

Nosotros le informaremos que tipo de beneficios el programa ofrese, quien califica y como y donde puede applicar. Tambien, si nesecita ayuda para llenar la applicacion nosotros le asiteremos.

Para mas informacion como puede ahorrar en beneficios del Social Security, llamar al South Texas Development Council Area Agency On Aging, a Juan G. Sanchez (956) 722-3995 or 1-800-292-5426.

P.O. Box 2187 • Laredo, Texas 78044 • Tel. (956) 722-3995 • Fax: (956) 722-2670 • 1-800-292-5426

Serving Webb, Zapata, Jim Hogg, and Starr Counties
Funded by the Texas Department on Aging

Savings for Medicare Recipients

Do you have Medicare and no help in paying your Premiums, deductibles, and coinsurance?

You might qualify for the state programs that could help you pay for medical expenses.

Programs

QMB= Qualified Medicare Beneficiaries
SLMB= Specified Low-Income Medicare Beneficiary
QI-1= Qualifying individual 1
QI-2= Qualifying individual 2

Learn about the savings programs and call the Area Agency on Aging, 533-0998 ext.145 and ask for Lety.

Programs that Help Pay Medical Expenses:

Choose your monthly income limit:

***QMB : Quality Medicare Beneficiaries*:**

Income Limits	Will Pay
$736 Individual $988 Couple	Premiums, deductibles & coinsurance

SLMB: Specified Low Income Medicare Beneficiary

Income Limits	Will Pay
$879 Individual $1,181 Couple	Medicare Part B premiums

QDWI:Qualified Disabled Working Individual

Income Limits	Will Pay
$1,452 Indivdual $1,955 Couple	Part A Premiums

QI-1: Qualifying Individual

Income Limits	Will Pay
$987 Individual $1,327 Couple	Medicare Part B premiums

QI-2: Qualifying Individual

Income Limits	Will Pay
$1,273 Individual $1,714 Couple	A small part of your Medicare Part B premiums

Middle Rio Grande Area Agency on Aging Services:

- ★ Nutrition Services
- ★ Transportation
- ★ Information, Referral & Assistance
- ★ Health Screening
- ★ Health Maintenance
- ★ Benefits Counseling
- ★ Care Management
- ★ Non-medical In-Home Services
- ★ Volunteer Opportunities
- ★ Nursing Home Ombudsman

AAA Staff:

☆☆☆

Gloria Perez, Director

San Juanita Galvan, Ombudsman/Elder Rights

Sophia Sifuentes, Care Coordinator

Erica Silva, Information, Referral & Assistance

Amparo Maldonado Outreach Specialist

1/800-224-4262

PH:830/876-1253

Fax: 830/876-9415

Middle Rio Grande Development Council
P.O.Box 1199/307 W. Nopal
Carrizo Springs, Texas 78834

Medicare Savings Program

For Medicare Part A recipients

Area Agency on Aging

of the

Middle Rio Grande Development Council

Carrizo Spgs

Do You Need Help to Pay Your Medical Expenses?

There are programs that may help you pay part of your medical expenses. If you qualify, you may not have to pay your Medicare premiums or out of pocket expenses.

How Do You Know If You Qualify?

You must have Medicare, Hospital Insurance (Part A). If you're not sure whether you have it, look on your Medicare card or call toll free
1-800-224-4262

How Do You Apply?

If you think you qualify you should call the Area Agency on Aging at
1-800-224-4262
Our staff will inform you of what documents you will need and will assist you in completing the application.

How Can You Get More Information?

Call Middle Rio Grande Development Council Area Agency on Aging at
1-800-224-4262
or 830-876-1253
For Deaf or Hearing Impaired Use
TDD #830-876-1260

Information You Should Gather

If you don't have it now, you can get it later. But Do Not hesitate to call us at
1-800-224-4262

- ☐ Award Letters (V.A. Social Security, Railroad Retirement)
- ☐ Earnings Statement
- ☐ Bank Statements
- ☐ Savings Passbook
- ☐ Certificate of Deposits
- ☐ Insurance Policies
- ☐ Insurance Policies (Life, burial, or hospitalization)
- ☐ Transfer Papers/deeds (for anything that you owned, but sold or gave away)
- ☐ Prepaid burial contracts

Area Agency on Aging

McAllen

You May Be Asked for the following information.

If you don't have this information now, you can get it later.

* Your Medicare Card
* Proof of identity
* Proof of residence
* Proof of all income. This includes pension checks, social secuirty payments, etc.
* Bank statements
* Proof of age (e.g. birth certificate)
* Insurance policies
* Financial statements from any stocks or bonds you own
* Proof of any funeral or burial policies you may have

***This brochure is also available in Spanish.

How do I apply?

Call the **Area Agency on Aging** and ask about programs that may assist you in paying for your Medicare premiums and other costs.

Lower Rio Grande Valley
Area Agency on Aging
311 North 15th Street
McAllen, Texas 78501

Toll Free: 1-800-365-6131

McAllen: 956-682-3481

Fax: 956-682-8852

E-mail aging@lrgvdc.org

For individuals that use TTY call 1-800-735-2989

Medicare Quality Savings Program

You Save

$50 on monthly premiums

$100 on annual deductibles

$792 on co-insurance and

20% of your Medicare cost.

Area Agency on Aging
OF THE LOWER RIO GRANDE VALLEY

A program of the Lower Rio Grande Valley Development Council and funded by the Department on Aging.

Do You Need Help Paying Your Medical Expenses?

There are programs that may help you pay part of your medical expenses. If you qualify, you may not have to pay your Medicare premiums or out of pocket expenses.

How Do You Know if You Qualify?

1. You must have Medicare, Hospital Insurance (Part A). If you're not sure whether you have it, look on your Medicare card or call toll free 1-800-365-6131.
2. Your financial resources, or the things you own are below $4000 for an individual and $6000 for a couple. Financial resources are things like bank accounts, stocks, and bonds. Some things are not counted like your home, one car, burial plots, furniture, and some life insurance.
3. Your income is below certain limits.
4. At least 65 years of age or older, or
5. Younger than 65 with certain disabilities,
6. If you have received disability benefits for 24 months.
7. Individuals with End Stage Renal disease,
8. Persons with permanent kidney failure who need dialysis or transplant.

Programs that Help Pay Medical Expenses:

QMB
Quality Medicare Beneficiaries:

Income limits	Provides
$736 Individual	$50 monthly premium, $100 annual deductible $792 co-insurance and 20 % of your Medicare costs.
$988 Couple	$50 monthly premium, $100 annual deductible $792 co-insurance 20 % of your Medicare costs.

SLMB
Specified Low Income Medicare Beneficiary

Income limits	Provides
$879 Individual	$50 Medicare Part B monthly premium
$1,181 Couple	$50 Medicare Part B monthly premium

QI-1:
Qualifying Individual

Income Limits	Provides
$987 Individual	$50 Medicare Part B monthly premium
$1,327 Couple	$50 Medicare Part B monthly premium

QDWI:
Qualified Disabled and Working Individuals

Income Limits	Provides
$1452 Individual	Full payment of Medicare Part B for eligible individuals who lose their Social Security disability check and Medicare benefits due to their earned income
$1955 couple	Full payment of Medicare Part B for eligible individuals who lose their Social Security disability check and Medicare benefits due to their earned income

Area Agency *on* Aging
RIO GRANDE COUNCIL OF GOVERNMENTS

Maybe you didn't know about the state programs that save money for Medicare recipients. Right now, only half of those who are eligible apply. And it's easy to apply. Check the chart inside and see if you qualify:

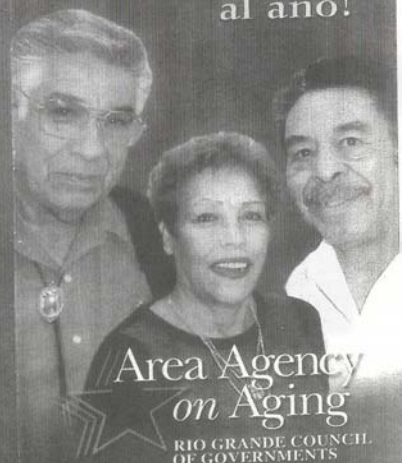
Programs That Will Help You With Your Medical Expense Payments:
(Select Your Monthly Income. Read From Left To Right)

YOUR MONTHLY INCOME LIMITS IN 2000*	PROGRAM WILL PAY	PROGRAM NAME
$736 Individual or $988 Couple	Medicare Part A and B premiums, deductibles, and coinsurance	Qualified Medicare Beneficiary (QMB)
$879 Individual or $1,181 Couple	Medicare Part B premiums	Specified Low-Income Medicare Beneficiary (SLMB)
$879 to $987 Individual or $1,181 to $1,327 Couple	Medicare Part B premiums	Qualifying Individual (QI-1)
$987 to $1,273 Individual or $1,327 to $1,714 Couple	A small part of your Medicare Part B premiums	Qualifying Individual (QI-2)

PLEASE CALL THE
BENEFITS COUNSELING STAFF
(915) 533-0998

AREA AGENCY ON AGING
1100 N. Stanton, Ste. 610
El Paso, Tx 79902
(915) 533-0998
1-800-333-7082

¿Tiene Medicare? ¡Usted podría ahorrar cientos de dólares al año!



Area Agency *on* Aging
RIO GRANDE COUNCIL OF GOVERNMENTS

Tal vez no sepa de los programas estatales que ayudan a los beneficiarios de Medicare a ahorrar dinero. Hasta ahora, sólo la mitad de las personas elegibles han solicitado estos beneficios. Revise el siguiente cuadro para ver si usted puede recibirlos:

Area Agency on Aging
RIO GRANDE COUNCIL OF GOVERNMENTS

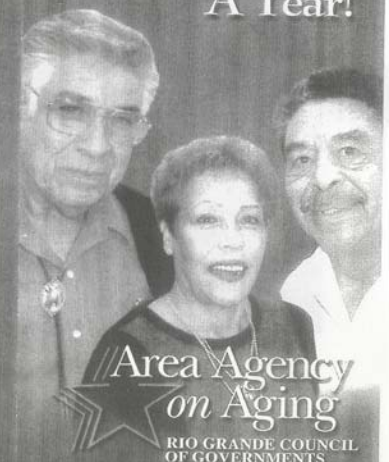
Programas para ayudarle con sus gastos médicos:
(Seleccione su ingreso mensual. Lea de izquierda a derecha)

LIMITE DE INGRESO MENSUAL EN EL 2001*	EL PROGRAMA PAGA:	NOMBRE DEL PROGRAMA
$736 Individual o $988 Por Pareja	Primas de Medicare Parte A y B, primas, deducibles y coaseguros	Qualified Medicare Beneficiary [Beneficiarios Calificados de Medicare] (QMB)
$879 Individual o $1,181 Por Pareja	Primas de Medicare Parte B	Specified Low-Income Medicare Beneficiary [Beneficiarios de Medicare con ingresos limitados] (SLMB)
$879 a $987 Individual o $1,181 a $1,327 Por Pareja	Primas de Medicare Parte B	Qualifying Individual [Individuo Calificado] (QI-1)
$987 a $1,273 Individual o $1,327 a $1,714 Por Pareja	Una pequeña parte de las primas de Medicare Parte B	Qualifying Individual [Individuo Calificado] (QI-2)

POR FAVOR DE HABLAR AL PERSONAL
DE CONSEJERIA DE BENEFICIOS
(915) 533-0998

AREA AGENCY ON AGING
1100 N. Stanton, Ste. 610
El Paso, Tx 79902
(915) 533-0998
1-800-333-7082

Are you on Medicare? You could be Saving $100's A Year!



Area Agency on Aging
RIO GRANDE COUNCIL OF GOVERNMENTS

HOW DO I GET QMB?

1) Fill out the Texas Department of Human Services Application for Assistance (Aged and Disabled) Form 1200EZ.

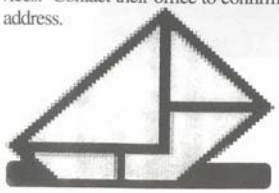
2) To complete the application, you will need:

- Your social security number
- Your Medicare card or other proof of Medicare eligibility.

You may also be required to show proof of the information you provide in the application, such as proof of income and resources, and proof that you live in Texas. Although you do not have to send proof with the application, it may speed up your application if you send copies of things like your bank statement.

DO NOT SEND ORIGINALS

3) After you have filled out the application, mail it to the "Aged and Disabled" Services of your local Texas Department of Human Services. Contact their office to confirm the address.



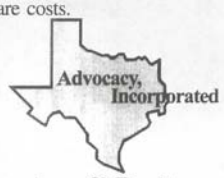
HOW DO I GET HELP WITH QMB?

If you need help or more information or an application, call your local office of the Texas Department of Human Services.

1-888-834-7406

1-888-425-6889 (TDD)

You will need to speak to someone in the "Aged and Disabled" or "Long Term Care" Services about QMB assistance for Medicare costs.



If you need more QMB assistance contact

Advocacy, Inc.
7800 Shoal Creek Blvd., Suite 171-E
Austin, TX 78757-1024
(512) 454-4816 (Voice/TDD)
(800) 252-9108 (Voice/TDD)
(512) 323-0902 (Fax)
http://www.advocacyinc.org

AAA
Austin

IF YOU ARE A PERSON WITH A DISABILITY

QMB

MAY HELP YOU

SAVE $546

PER YEAR

IN MEDICARE EXPENSES

WHAT IS QMB?

QMB means
Qualified Medicare Beneficiary.

It is a program that pays monthly premiums and other medical costs for Medicare recipients. It is paid by the State through Medicaid.

WHO CAN GET QMB?

You may qualify for QMB or other similar benefit programs (known as SLMB, QI-1, or QI-2) **if:**

1) you have a disability ***and***
2) you have a work history or have a parent or spouse who has work history ***and***
3) you are over 18 and receive disability benefits through SSDI (Social Security Disability Insurance) or RSDI (Retirement, Survivors, and Disability Insurance) based on the work history ***and***
4) based on receiving your SSDI or RSDI payments for 24 months, you are receiving or are eligible for Medicare ***and***
5) your income and assets are within certain amounts (See income chart and "ASSETS").

- **If you are 65 or older, you may also qualify for QMB.**
- **Some kids may qualify for QMB if they have worked or if they have renal disease.**

Gross Monthly Income Limits * Effective 4/1/2000 to 3/31/2001	You may qualify for this program:	This program will pay:
$716 Individual or $958 Couple	Qualified Medicare Beneficiary (QMB)	Your Medicare premiums, deductibles, and coinsurance
$855 Individual or $1,145 Couple	Specified Low-Income Medicare Beneficiary (SLMB)	Your Medicare Part B premiums
$960 Individual or $1,286 Couple	Qualifying Individual (QI-1)	Your Medicare Part B premiums
$1,238 Individual or $1,661 Couple	Qualifying Individual (QI-2)	A small part of your Medicare Part B premiums

*** Certain portions of earned income are not counted.**

ASSETS (or resources)

Your assets or resources (the things you own) must be worth less than
$ 4000 if you are single or less than
$ 6000 if you are a couple.

Some things (like the home you live in, one car, burial plots, furniture, and some life insurance) are not counted in these asset or resource limits.

Here are examples of things that are counted:

- second cars, trucks, boats, and other vehicles
- real estate (but ***not*** your home and the land you live on)
- bank accounts, stocks, bonds, or other cash holdings
- and other things of value.

These income and asset limits are guidelines. The only way to know for sure if you are eligible is to apply.

Hi! I'm QMB. I can pay your Medicare premiums and save you a lot of money!

Ask for QMB
1-800-252-9240
Pida QMB

¡Ola! Yo soy QMB. Yo puedo pagarle sus primas de Medicare. Puedo ahorrarle mucho dinero.

Here's the stinger: You could be losing $546 a year or more. That's the total of what's taken out of your Social Security check every month for the Medicare Part B payment. That's quite a chunk!

The thing is, QMB and some programs like it can put that money back in your pocket where it belongs.

QMB is the most generous of these programs. QMB stands for Qualified Medicare Beneficiary. It takes care of your deductible and co-payment as well as all Medicare premiums.

People with disabilities or those who are 65 or older may be eligible for Medicare and QMB. You could be eligible for QMB if your monthly income is $716 or less. If you're married, the monthly income limit is $958. Assets--that is, the things you own--have to fall below a certain limit in value, too. The good news is that your home and in most cases, your car, aren't counted when your assets are added up. Neither are things like burial plots. The value of your remaining property can be $4,000 if you're single or $6,000 if you're married.

Hey, wait a minute! I'm SLMB. How about me?

If you don't qualify for QMB, there are other programs that might work for you. One of these is SLMB (Specified Low Income Medicare Beneficiary). Your income can be higher on SLMB, but SLMB pays only the Part B Medicare premium.

In fact, there are two other programs with even higher income limits than QMB and SLMB buzzing around out there. The first is QI 1 (Qualified Individual 1) and it pays the Part B premium.

QI 2 (Qualified Individual 2) has the highest income limit of all. It pays only a small portion of the part B premium, however.

There's a chart on the reverse side listing all of the income limits. The way the income that's counted is figured is complicated so call a benefits counselor to find out for sure if you qualify.

1-800-252-9240

Persons with disabilities can call Advocacy, Inc. at 1-800-252-9108 (Voice/TDD)

Si usted no califica para QMB, hay **otros programas** que podran ayudarle. Unos de ellos es SLMB (Specified Low Income Medicare Beneficiary) beneficiario de Medicare con ingresos bajos; sus ingresos pueden ser más en este programa pero paga nada más los primas de Medicare Parte B.

En realidad, hay dos programs más con limites de ingresos más altos que QMB y SLMB zumbando por estos lugares. El primero es **QI-1 (Individuo Calificado 1)** que paga el prima de Medicare Part B.

QI-2 (Individuo Calificado 2) require el ingreso más alto de todos estos programas. El limite es que paga nada más parte del prima de Medicare Parte B.

La carta esplica todos los programas y los límites de ingresos. El ingreso que se cuentan para cada programa es complicado para calcular. Llamele a su aconsejador de beneficios.
This chart shows the gross monthly income limits, but because some types of income aren't counted, you won't really know if you're eligible until you talk to a benefits counselor.

QMB	Soltero/Single	$ 716
	Casado/Married	$ 958
SLMB	Soltero/Single	$ 855
	Casado/Married	$1,146
QI 1	Soltero/single	$ 960
	Casado/Married	$1,287
QI 2	Soltero/Single	$1,238
	Casado/Married	$1,662
Assets	Soltero/single	$4,000
Recursos	Casado/Married	$6,000

¿Preguntas? Questions?

1-800-252-9240

Persons with disabilities can call Advocacy, Inc. at 1-800-252-9108 (Voice/TDD)

Y tambien puede llamar/
You can also call:
Legal Hotline for Older Texans
1-800-622-2520

QMB Project Partners include:

Advocacy, Inc.
1-512-454-4816
1-800-252-9108 (voice/TDD)
Coastal Bend Legal Services
1-361-576-1274
Gulf Coast Legal Foundation
1-713-982-7342
Texas Legal Services Center
1-512-477-6000

Aqui esta el piquete: Puedes estar perdiendo $546 o más cada mes---el total de lo que le quitan de su cheque de seguro social para los pagos de prima de Medicare Parte B.

Lo que pasa, es que QMB y otros programas similares, pueden regresarle este dinero a su bolsa, donde merese estar.

QMB es el más generoso de estos programas. QMB es el nombre en inglés del programa,

Qualified Medicare Beneficiary, beneficario calificado de Medicare, que paga su deductible, co-pagos, y todas sus primas de Medicare.

Personas con inhibilidades o personas de 65 años o más podrán ser eligible para recibir Medicare y QMB. Usted podrá ser eligible para recibir QMB si su ingreso es $716 o menos. Si usted es casado el ingreso mensual es $958.

Sus fondos o capital, esas cosas que sean suyas, también tienen que ser bajo de cierto limite en valor, pero lo major es que su hogar y casi siempre su auto no se cuentan en calcular el valor de su capital. Su sepultura no se cuenta tampoco. El resto de su capital puede ser $4,000 si es soltero o $6,000 si es casado.

¡Esperate tantito!
¡Yo soy SLMB!
¿Y yo?

Texas

Tables and Figures

Table F-1

Texas: Percent Change in Person-Years of Enrollment Between Baseline and Grant Periods by Region in the Demonstration Area

	Lower Rio Grande	Middle Rio Grande	Rio Grande	South Texas
	%	%	%	%
# of Person-Years	7.8	6.0	9.3	7.7
Age				
<65	31.0	25.5	28.0	32.5
65-74	5.6	6.6	8.3	5.7
75-84	0.1	0.8	1.9	2.3
85+	-7.6	-13.8	-9.3	-12.1
Gender				
Male	8.4	7.4	10.0	8.8
Female	7.3	4.8	8.8	6.7
Race				
White	-1.8	3.5	8.0	5.4
Black	30.7	-4.6	8.3	-50.0
Hispanic	8.7	6.5	9.4	7.8
Asian/Pacific Islander	15.7	0.0	15.2	0.0
Native American	19.8	-8.3	18.2	0.0
Unknown	5.6	0.0	83.7	0.0
Area of Residence				
Urban	7.8	0.0	9.0	5.5
Rural	7.3	6.0	18.0	12.9
Program Eligibility				
MQMB (SSI)	8.1	4.4	5.5	6.8
QMB	3.3	2.4	5.5	3.1
SLMB	13.3	13.5	17.2	15.1
MSLMB (Med.Needy)	23.2	28.6	18.0	21.2

SOURCE: HER analysis of Texas Medicaid Eligibility Data, December 1999-September 2001.

Figure F-2

Texas: Number of Enrollees by Program Eligibility and Month
(December 1999 - September 2001)

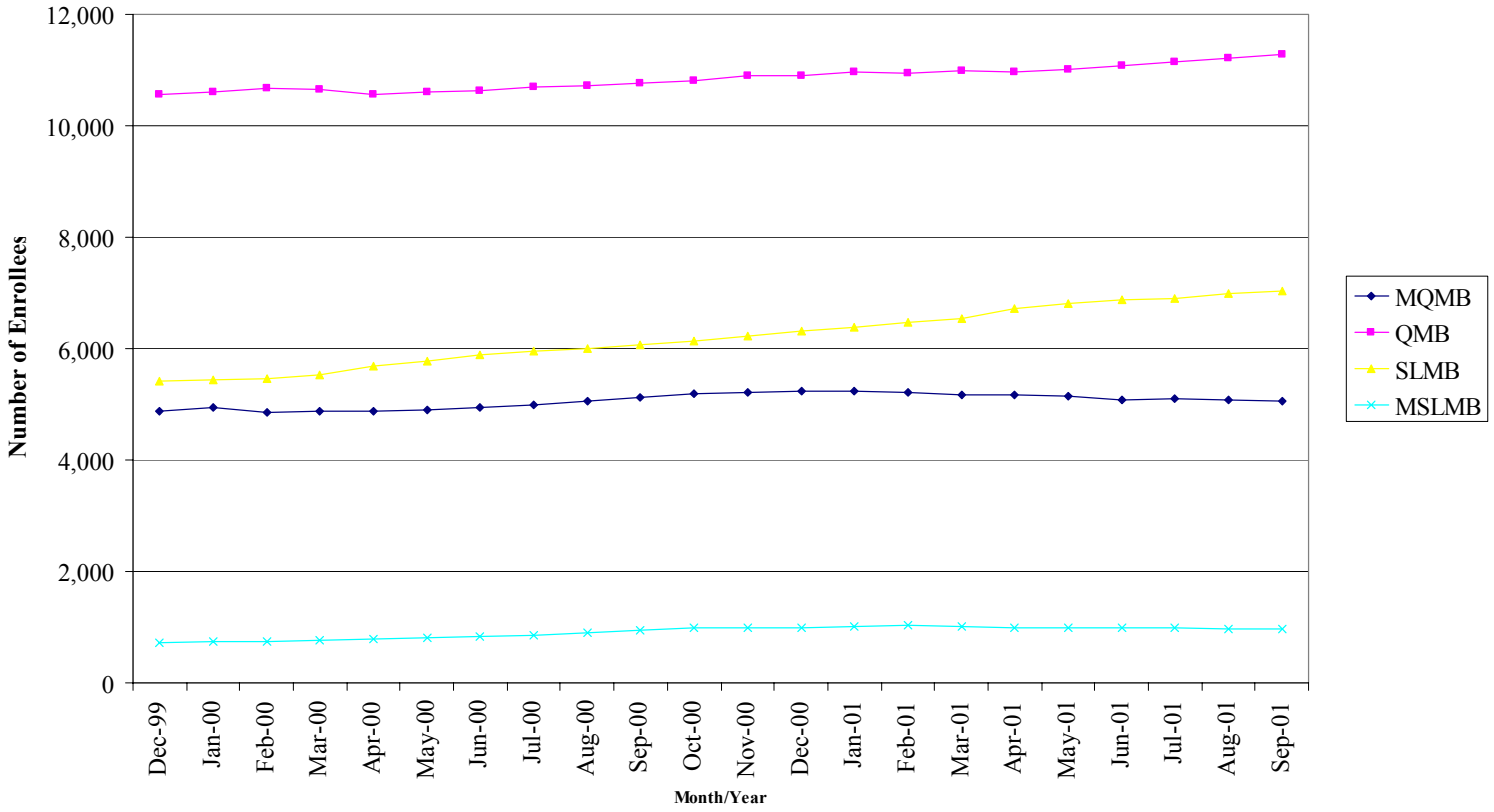
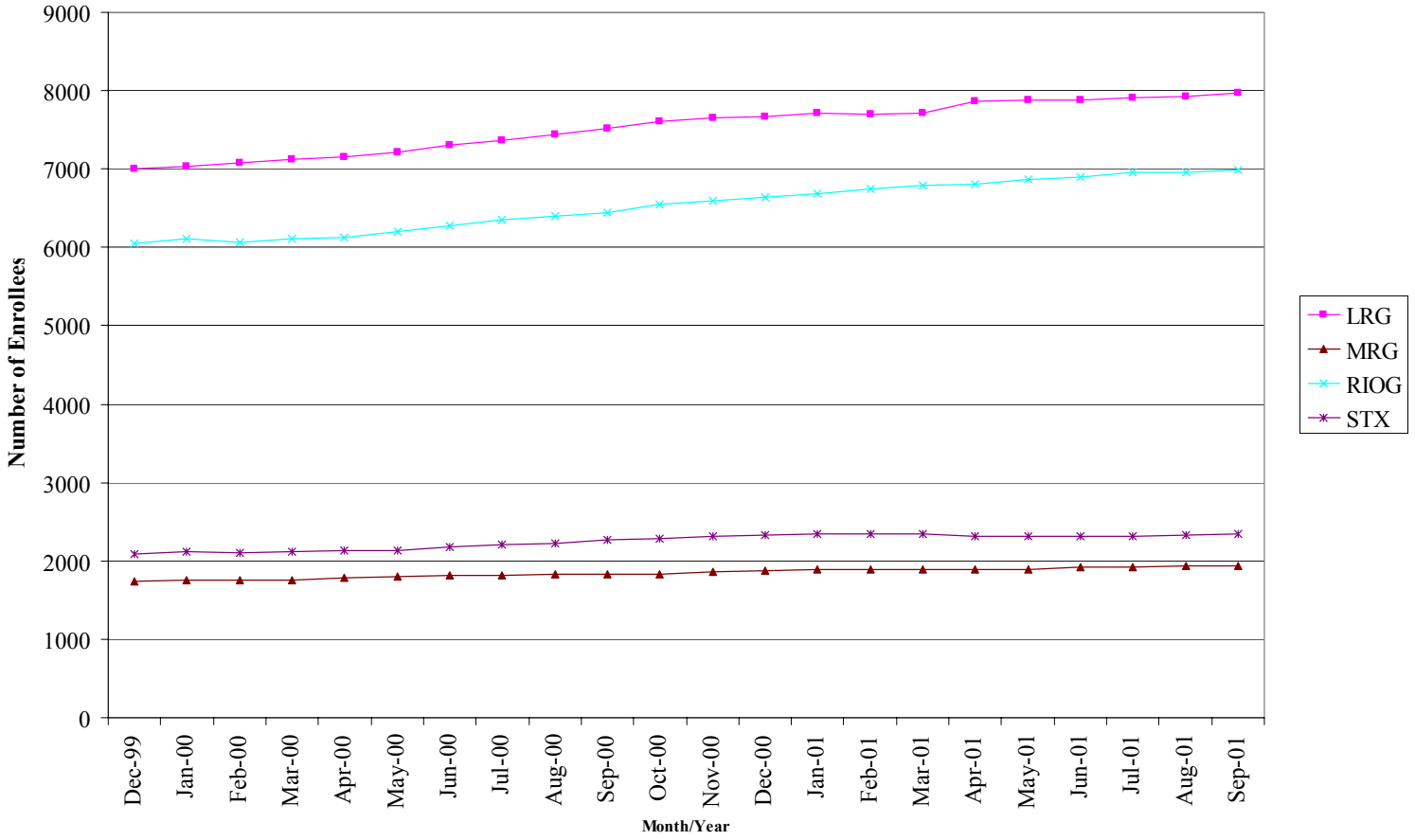


Figure F-3

Texas: Number of Enrollees by Region and Month
(December 1999 - September 2001)



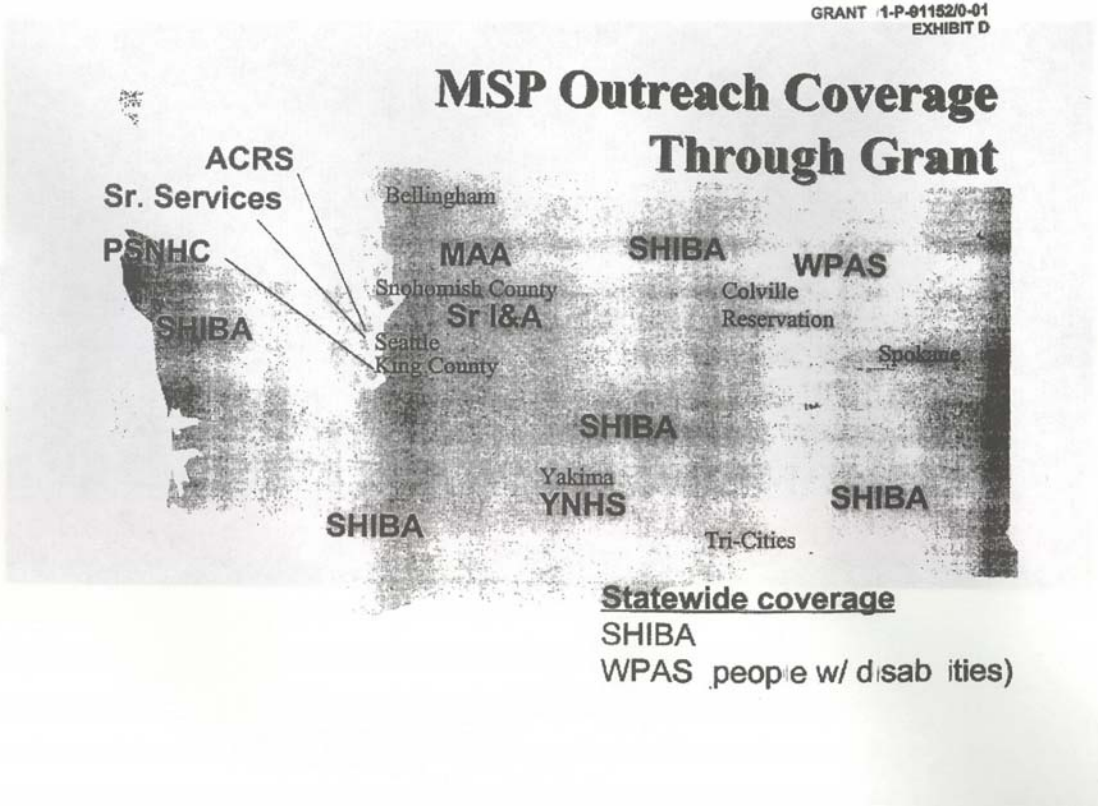
APPENDIX G

WASHINGTON

Map of Washington

Figure G-1

GRANT 1-P-91152/0-01
EXHIBIT D



Washington

Enrollment Application and Outreach Materials

APPLICATION FOR MEDICARE PREMIUM ASSISTANCE

The State of Washington Department of Social and Health Services (DSHS) has programs available to help eligible individuals pay for their Medicare Part B premium. The programs are designed to help Medicare beneficiaries pay some or all of their Medicare Part B premium.

QMB
Qualified Medicare Beneficiary

This program is for a person who has applied for or is enrolled in Medicare Part A and has limited assets and income that is at or below 100% of the Federal Poverty Level (FPL). The QMB program provides for payment of the Medicare Part B premium and covers Medicare deductibles and coinsurance charges.

SLMB
Specified Low-Income Medicare Beneficiary

This program is for a person who can enroll in Medicare Part A who has limited assets and income that is more than 100% FPL but not more than 120% of the FPL. The SLMB program provides for payment of the Medicare Part B premium only.

ESLMB
Expanded Specified (or QI-1) Low-Income Medicare Beneficiary

This program is for a person who can enroll in Medicare Part A who has limited assets and income that is more than 120% of the FPL but not more than 135% of the FPL. Persons cannot be Medicaid eligible and receive ESLMB. The ESLMB program provides for payment of the Medicare Part B premium only. Funding for this program is limited.

The current Federal Poverty Level (FPL) amounts are included on an insert with this application.

HOW DO I QUALIFY?

1. You must be able to get Medicare Parts A and B.
2. Your assets, such as bank account, stocks and bonds cannot exceed $4,000 for one person or $6,000 for a couple. The assets and income of your spouse are counted even though your spouse may not be getting Medicare or applying for benefits.
3. Your income must be within the limits for the program. The current income limits are included on an insert with this application. These income limits are updated yearly. If your income is less than these limits, you may qualify for Medicaid benefits. To apply for Medicaid, contact the DSHS Community Services Office (CSO) that serves the area where you live. Check your telephone book in the state government pages to find the number of the CSO serving your area.

HOW DO I APPLY?

1. Complete the attached application for the QMB, SLMB, and ESLMB (or QI-1) programs.
2. Attach proof of your income, assets, identification, and Medicare identification card. Send copies, not originals.
3. Mail the application and copies of documents listed above in the enclosed, self-addressed, postage paid envelope.
4. It may take up to 45 days from the date DSHS receives your application until you hear from DSHS. If you have not heard anything by that time, your local Community Services Office (CSO) and inquire about the status of your application.

IF YOU NEED MEDICAID ASSISTANCE, CASH ASSISTANCE, OR FOOD ASSISTANCE, YOU MUST COMPLETE A DIFFERENT APPLICATION. PLEASE CALL YOUR COMMUNITY SERVICES OFFICE (CSO) AND THEY WILL SEND YOU THE PROPER FORM.

APPLICATION FOR MEDICARE PREMIUM ASSISTANCE

Please read the following before completing the application.

You will need to answer all questions before we will know if we can help you. If you need help completing any part of this form, call your local Community Services Office.

STEP #1 Please print.

1. LAST NAME	FIRST NAME	MIDDLE INITIAL

2. RESIDENCE ADDRESS	CITY	STATE	ZIP CODE

3. MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

4. TELEPHONE NUMBERS	5. DO YOU HAVE TROUBLE SPEAKING, READING OR WRITING ENGLISH?
HOME	☐ YES ☐ NO
MESSAGE	DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO IF YES, WE WILL PROVIDE ONE. WHAT LANGUAGE DO YOU SPEAK? _____

GENERAL INFORMATION

IF MARRIED, LIST SPOUSE ALSO. USE LEGAL NAMES.

NAME (LAST, FIRST, MI)	RELATIONSHIP TO YOU	DATE OF BIRTH	APPLYING FOR BENEFITS? YES NO	SOCIAL SECURITY NUMBER	SEX M OR F
	SELF				
	SPOUSE				

MEDICAL COVERAGE INFORMATION

CHECK WHICH APPLIES	MEDICARE NUMBER
I/we have applied for or receive: Medicare Part A Self Yes ☐ No ☐	
Spouse Yes ☐ No ☐	
I/we are entitled to or receive: Medicare Part B Self Yes ☐ No ☐	
Spouse Yes ☐ No ☐	

I/we have other medical coverage. Yes ☐ No ☐

If yes, what insurance and who does it cover? _____

_____

_____

_____

INCOME

For each person that you included on this application who has income, list the income below. List the income amount before deductions (such as taxes or insurance) are taken out. Income includes but is not limited to:

- Wages
- Self- employment
- Commissions
- Room and Board/Rent
- Railroad Benefits
- Social Security Benefits Insurance
- Veterans Benefits
- Alimony Benefits
- Unemployment or Worker Compensation
- SSI/Public Assistance
- Pensions/Retirement
- Dividends and Interest
- Other

NAME	EMPLOYER OR SOURCE OF INCOME	AMOUNT BEFORE DEDUCTIONS	HOW OFTEN RECEIVED?

ASSETS

A. My assets are worth $4,000 or less for one person or $6,000 or less for a couple. (Assets include such things as bank accounts, certificates of deposit, savings bonds, IRAs, stocks and bonds, mutual funds, cash) Yes ☐ No ☐

If yes, please list below:

NAME OF OWNER	TYPE/ACCOUNT NUMBER OF THE ASSET	CURRENT VALUE
		$
		$
		$
		$
		$
		$
		$

B. Do you or your spouse own or are you buying a car or other vehicle (truck, boat, motor home, motorcycle, camper and/or trailer?) Yes ☐ No ☐

If yes, please list below:

NAME OF OWNER	ITEM	YEAR	MAKE/MODEL	USED FOR TRANSPORTATION TO MEDICAL APPOINTMENTS	VALUE	AMOUNT OWED
				Yes ☐ No ☐	$	$
				Yes ☐ No ☐	$	$
				Yes ☐ No ☐	$	$

C. Do you or your spouse have a whole life insurance policy with cash value over $1,500.00? Yes ☐ No ☐

If yes, please list below:

POLICY OWNER	NAME OF INSURANCE COMPANY/POLICY NUMBER	FACE VALUE	CASH VALUE	WHO IS COVERED?
		$	$	
		$	$	
		$	$	
		$	$	

READ CAREFULLY BEFORE SIGNING

I UNDERSTAND THAT:

- I must report immediately to the Department of Social and Health Services (DSHS), in writing, or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by DSHS or other state or federal agencies.
- I must provide proof I am eligible for help. DSHS may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.

DECLARATION AND SIGNATURE(S)

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPLICANT		DATE
SIGNATURE OF APPLICANT		DATE
SIGNATURE OF PERSON ASSISTING APPLICANT	ORGANIZATION	DATE

I authorize DSHS to release information regarding my application for Medicare premium assistance to the person assisting with completion of this application or representative from that person's organization.

SIGNATURE OF APPLICANT	DATE

VOLUNTARY INFORMATION

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for benefits.

- ☐ Caucasian
- ☐ Hispanic
- ☐ Black
- ☐ Native American/Alaskan Native
- ☐ Vietnamese/Laotian/Cambodian
- ☐ Other:
- ☐ Other Asian or Pacific Islander _____

STEP #2

ATTACH PROOF

We will need proof of the information you have provided to process your application. Examples of proof are listed below. You are not limited to these examples.

PLEASE SEND COPIES -- NOT ORIGINALS

Identification	Driver's License, Passport, Photo ID
Medicare	Medicare ID Card
Income, other than Social Security	One Month's current Pay Stubs, Proof of Pension, Tax Forms or other Records of Self-employment Income, Copies of Check Stubs or Statements from the Source of Income.
Assets	Bank Statements, Insurance Policies, Tax Assessment Notices, Vehicle Registration.

If you are unable to obtain proof of the information you have provided, DSHS can help you. Please attach a note explaining why you are unable to provide the proof.

STEP #3

Sign and date your application and mail it, along with copies of your documents, in the enclosed envelope.

Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, sex, or disability.

Medicare Savings Programs

help people on Medicare pay some or all Medicare-related costs. Call the number on the front of this brochure for personalized assistance.

The Washington Dual Eligible Outreach Coalition, a statewide network of member organizations, was created to inform Washington residents about the existence of these programs. In partnership with the Health Care Financing Administration (HCFA), the Washington Department of Social and Health Services (DSHS), the Coalition demonstrates a commitment from all levels of public and human service organizations to ensure that our state's low income Medicare beneficiaries are informed of their benefits.

These agencies, with the help of the Washington Dual Eligible Outreach Coalition, are providing outreach and assistance to Dual Eligible individuals.

- *Asian Counseling and Referral Service*
- *Puget Sound Neighborhood Health Centers*
- *Senior Services of Seattle/King County*
- *Senior Services of Snohomish County*
- *Washington Protection and Advocacy System (WPAS)*
- *Washington State Health Insurance Benefits Advisors (SHIBA)*
- *Yakima Neighborhood Health Services*

YOU MAY QUALIFY FOR HELP WITH PAYING YOUR MEDICARE COSTS!

Medicare Savings Programs

can save you money. It's easy to apply and we can help!

Senior Rights Assistance
1601 Second Avenue,
Suite 800
Seattle, WA 98101
(206) 448-5720

Did you know?

With the Medicare Savings Programs, you can get help paying for Medicare costs!

As a Medicare beneficiary you may be eligible for a program that would pay your Medicare premiums and other Medicare-related costs. These programs are for Medicare beneficiaries who have low income and limited assets.

To qualify...

your income must fall within at least one of these guidelines listed below.

	Individual	Couple
QMB	$736	$988
SLMB	$879	$1,181
QI-1	$987	$1,327

To qualify for any of the Medicare Savings Programs,

your assets must be less than $4,000, or $6000 for a couple.

Assets include:

- Cash
- Bank accounts
- Certificates of deposit
- Savings bonds
- Stocks
- Real property (except the home you live in)
- Recreational vehicles

Assets **NOT** included in the limit:

- The home you live in
- One car, if needed to get to medical care
- Burial plots
- Furniture
- Life insurance with a cash value of $1,500 or less

What are the benefits?

Qualified Medicare Beneficiary (QMB)

- Part A Premium, if any
- Part B Premium
- All Medicare co-insurance and deductibles

Specified Low-Income Medicare Beneficiary (SLMB) or Expanded Specified Low-Income Medicare Beneficiary (ESLMB)/Qualified Individual (QI-1)

- Part B Premium

With all of the Medicare Savings Programs listed above, the monthly Medicare Part B premium will no longer be deducted from your monthly Social Security benefit.

To apply for these Medicare Savings Programs,

contact the agency listed on the front of this brochure for information and assistance. Or you can contact your local Community Services Office (CSO).

Medicare Savings

Programs help people on Medicare pay some or all Medicare-related costs. Call the number on the front of this brochure for personalized assistance.

We are members of the Washington Dual Eligible Outreach Coalition, a statewide network created to inform Washington residents about the existence of these programs. Our partnership with the Health Care Financing Administration, the Washington Department of Social and Health Services, and other member organizations of the Washington Dual Eligible Outreach Coalition demonstrates a commitment from all levels of public and human service organizations to ensure that our state's low income Medicare beneficiaries are informed of their rights.

- *Asian Counseling and Referral Service*
- *Puget Sound Neighborhood Health Centers*
- *Senior Services of Seattle/King County*
- *Senior Services of Snohomish County*
- *Washington Protection and Advocacy System (WPAS)*
- *Washington State Health Insurance Benefits Advisors (SHIBA)*
- *Yakima Neighborhood Health Services*

YOU MAY QUALIFY FOR HELP WITH PAYING YOUR MEDICARE COSTS!

Medicare Savings Programs

can save you money.
It's easy to apply and we can help!

45th Street Clinic
1629 N. 45th St./Seattle 98103
Contacts: Jose Bon 206 633-7636
Felicia Estrada 633-7635

Did you know?

With the Medicare Savings Programs, you can get help paying for Medicare costs!

As a Medicare beneficiary you may be eligible for a program that would pay your Medicare premiums and other Medicare-related costs. These programs are for Medicare beneficiaries who have low income and limited assets.

To qualify...

your income must fall within at least one of these guidelines listed below.

	Individual	Couple
QMB	$716	$ 958
SLMB	$855	$1,145
QI-1	$960	$1,286

To qualify for any of the Medicare Savings Programs,

your assets must be less than $4,000, or $6000 for a couple.

Assets include:
- Cash
- Bank accounts
- Certificates of deposit
- Savings bonds
- Stocks
- Real property (except the home you live in)
- Recreational vehicles

Assets **NOT** included in the limit:
- The home you live in
- One car, if needed to get to medical care
- Burial plots
- Furniture
- Life insurance with a cash value of $1,500 or less

What are the benefits?

Qualified Medicare Beneficiary (QMB)
- Part A Premium, if any
- Part B Premium
- All Medicare co-payments and deductibles

Specified Low-Income Medicare Beneficiary (SLMB) or Expanded Specified Low-Income Medicare Beneficiary (ESLMB)/Qualified Individual (QI-1)
- Part B Premium

With all of the Medicare Savings Programs listed above, the monthly Medicare Part B premium will no longer be deducted from your monthly Social Security benefit.

To apply for these Medicare Savings Programs,

contact the agency listed on the front of this brochure for information and assistance. Or you can contact your local Community Services Office (CSO).

DID YOU KNOW?

You can get help paying for Medicare costs!

As a Medicare beneficiary you may be eligible for a program that would pay for your Medicare Part B premium. These programs are for Medicare beneficiaries who have low income and limited assets.

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Important note: If you don't speak English, tell the person who answers the phone what language you speak. An interpreter will help you.

Medical Assistance Administration April 1, 2001

To qualify for any of the programs listed, your assets must be under **$4,000** or **$6,000** for a couple. Assets include:

- Cash,
- Bank accounts,
- Certificates of deposit,
- Savings bonds,
- Stocks,
- Real property (except the home you live in),
- Recreational vehicles

Assets **NOT** included in the limit:

- The home you live in
- One car, if needed to get medical care
- Burial plots
- Furniture
- Life insurance with a cash surrender value of **$1,500 or less**

Qualified Medicare Beneficiary (QMB) program

QMB pays your Part B premium and the cost, if any, of your Part A premium. QMB also pays your Medicare co-payments and deductibles. To be eligible, your income must be no more than:

- **$736* for one person, or**
- **$988* for a couple**

*This income amount already has a $20 disregard added.

Specified Low-Income Medicare Beneficiary (SLMB) or the Expanded Specified Low-Income Medicare Beneficiary (ESLMB) – QI-1 program

SLMB and ESLMB (QI-1) pay your Part B premium only. The Part B premium amount is then added back into your monthly Social Security benefit. The maximum monthly income you can have for one of these programs is:

- **$879* for one person, or**
- **$1,327* for a couple**

☎ **To apply for QMB, SLMB or ESLMB (QI-1),** contact your local Community Services Office (CSO).

Qualified Individual (QI-2) program

If you are not eligible for the other programs, but your income is between:

- **$988* - $1,273* for one person, or**
- **$1328* - $1,714* for a couple**

we can help you with the QI-2 program by paying **$3.09** of your monthly Part B premium. This is paid to you once a year.

☎ **To apply for the QI-2 program,** call toll-free 1-800-562-6136 and we will mail you an application.

Washington

Tables and Figures

Figure G-2

Washington: Number of Enrollees by Program Eligibility and Month
(October 1999 - December 2001)